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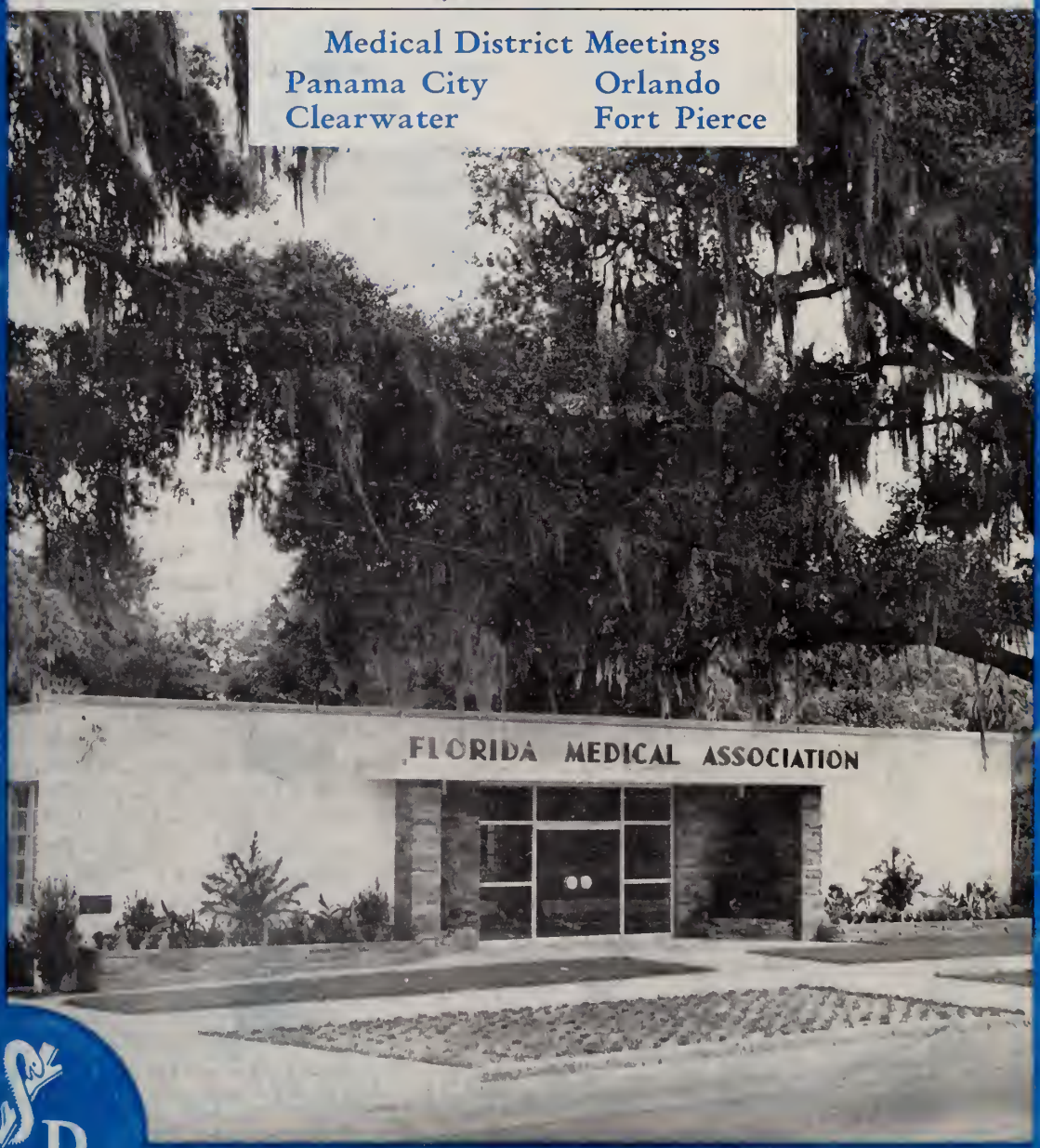
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The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLIV JULY, 1957 No. 1

Medical District Meetings

Panama City — Orlando
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REFERENCES:

(1) Metzger, W. I., & Jenkins, C. J., Jr.: *Pediatrics* **18**:929, 1956. (2) Altemeier, W. A.: *Postgrad. Med.* **20**:319, 1956. (3) Cohen, S.: *Postgrad. Med.* **20**:483, 1956. (4) Rantz, L. A., & Rantz, H. H.: *Arch. Int. Med.* **97**:694, 1956. (5) Bennett, I. L., Jr.: *West Virginia M. J.* **53**:55, 1957. (6) Hughes, J. G., & Carroll, D. S.: *Pediatrics* **19**:184, 1957. (7) Kempe, C. H.: *California Med.* **84**:242, 1956. (8) Spink, W. W.: *Ann. New York Acad. Sc.* **65**:175, 1956. (9) Yow, E. M.: *GP* **15**:102, 1957. (10) Wise, R. I.; Cranny, C., & Spink, W. W.: *Am. J. Med.* **20**:176, 1956. (11) Royer, A.: Scientific Exhibit, 89th Ann. Conv. Canad. M. A., Quebec City, Quebec, June 11-15, 1956.

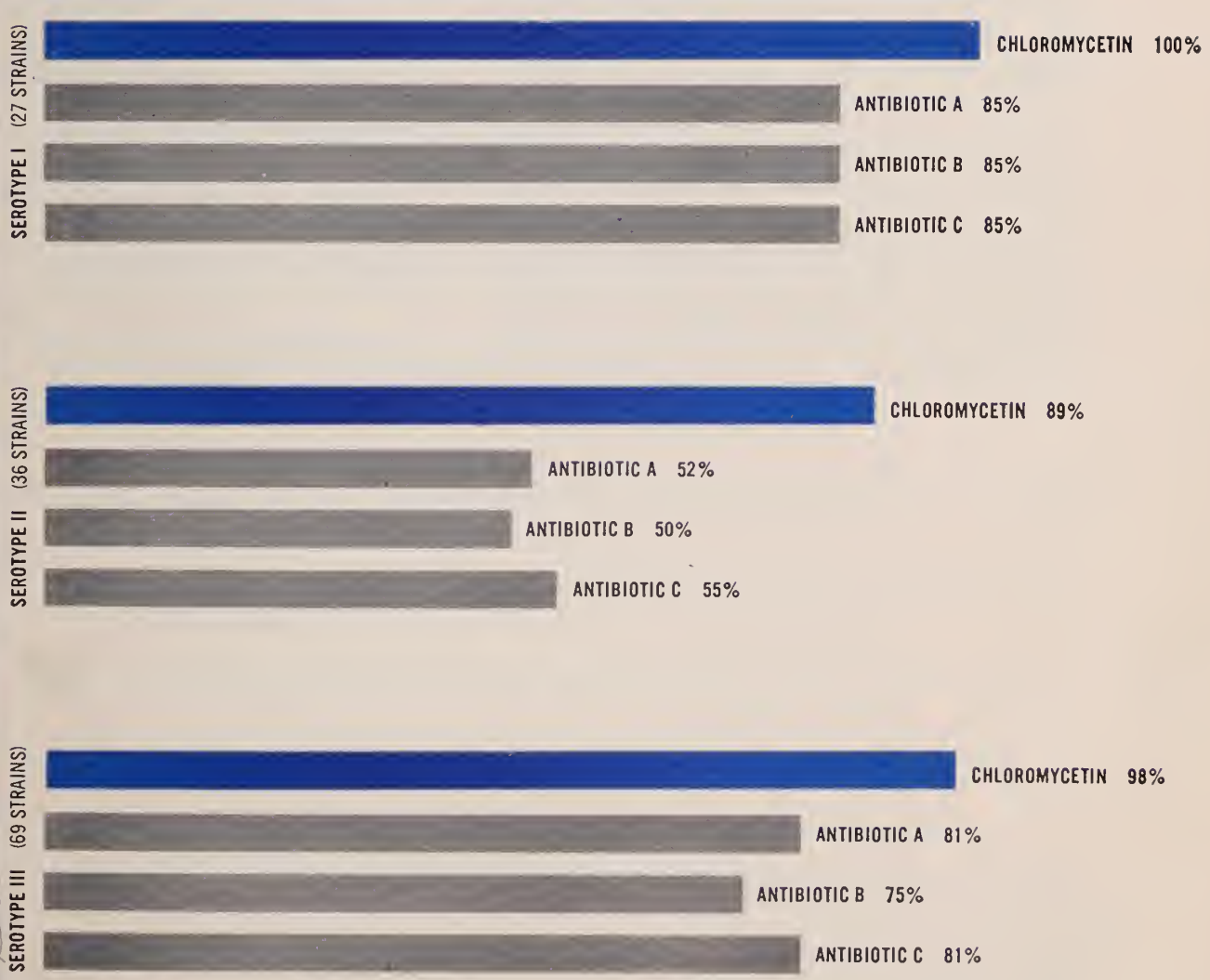
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*This graph is adapted from Metzger & Jenkins.[1]
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The Journal of the Florida Medical Association

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VOLUME XLIV, No. 1 • *July, 1957*

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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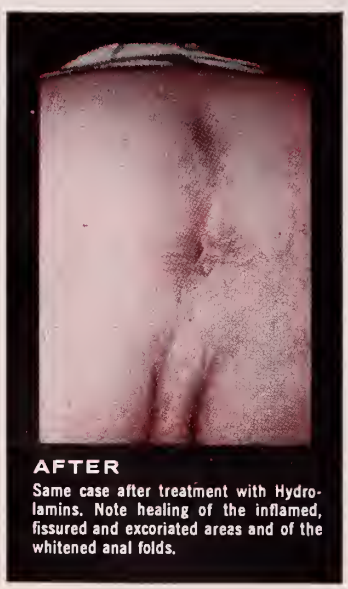


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1. Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18:59 (Feb.) 1951.
2. Fromer, J.L.: Dermatologic Concepts and Management of Pruritus Ani, Am. J. Surg. 90: 805 (Nov.) 1955.

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1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954

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1. Jackson, P. L.: Iron Deficiency Anemia in Infants, Editorial, J.A.M.A. *160*:976 (Mar. 17) 1956.

2. Martin, E. A.: Roberts' Nutrition Work with Children, Chicago, The University of Chicago Press, 1954, p. 211.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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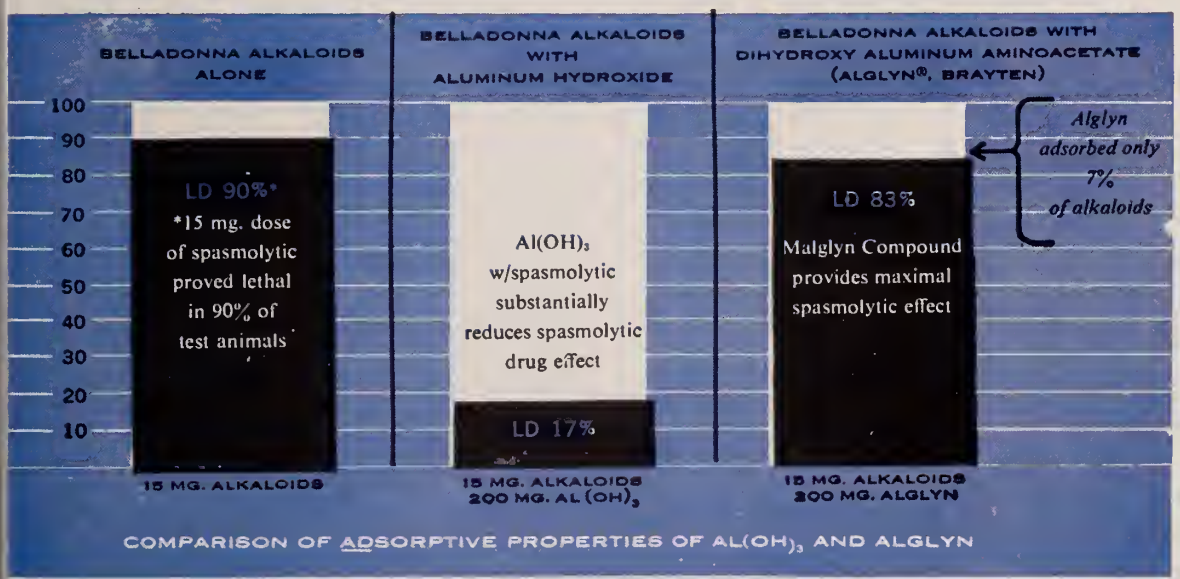
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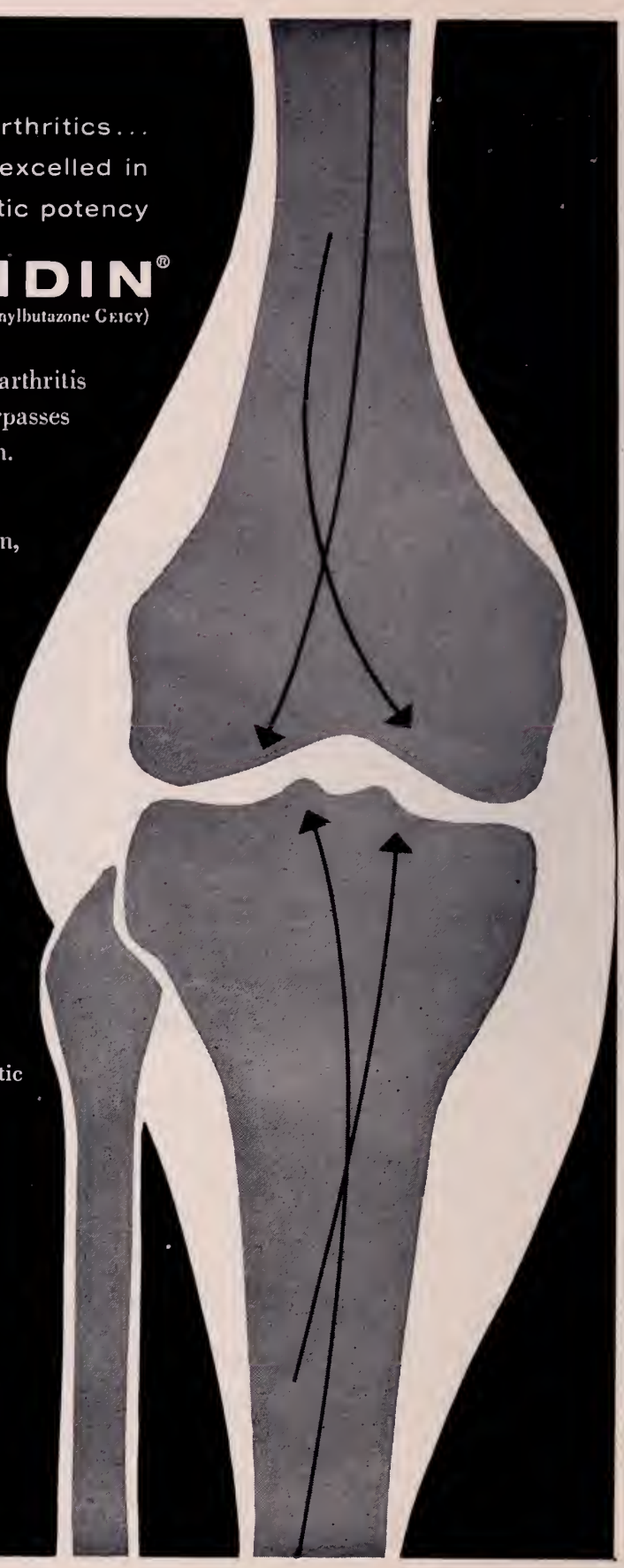
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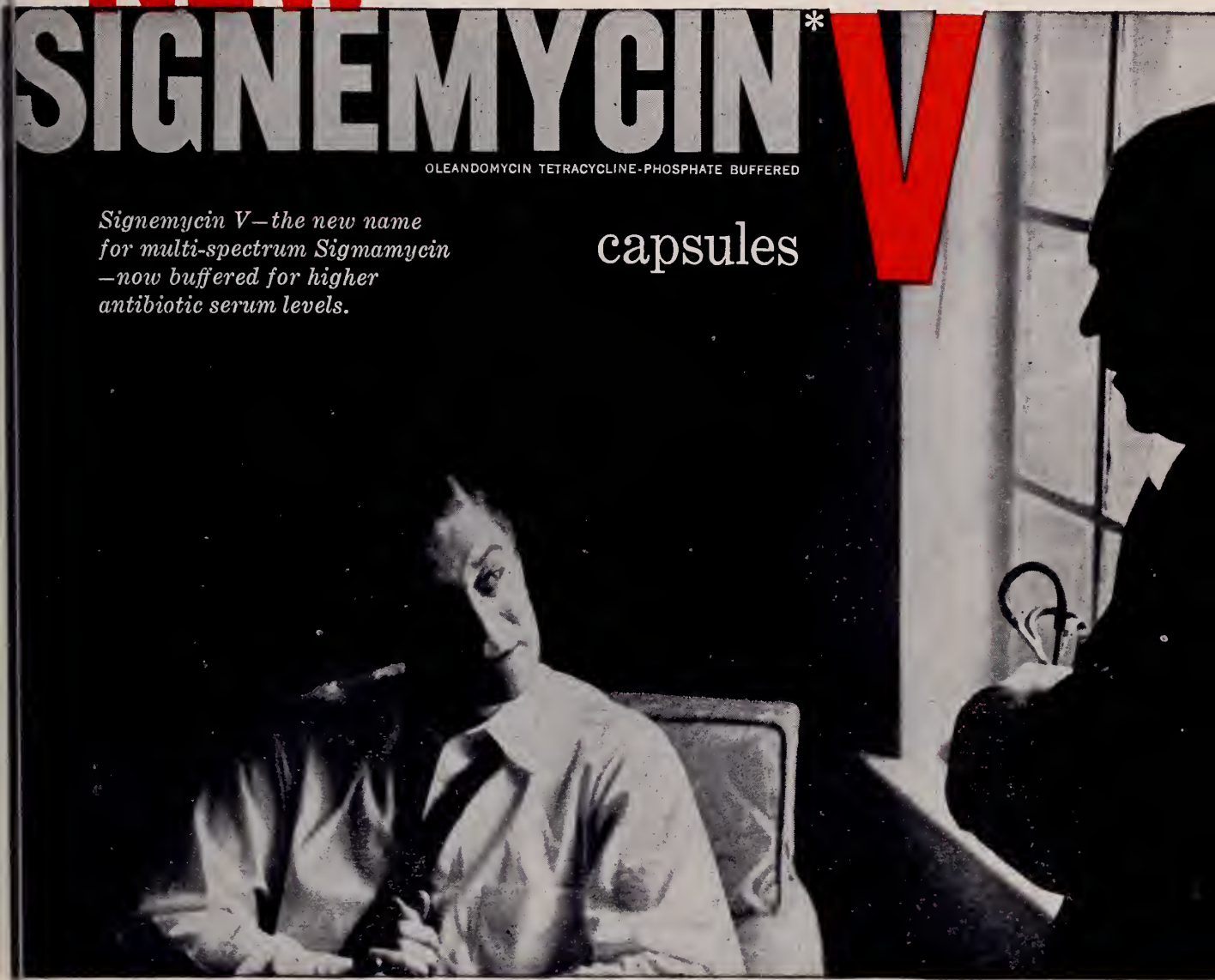
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The Journal of The Florida Medical Association
PUBLISHED MONTHLY

Volume XLIV | Jacksonville, Florida, July, 1957 | No. 1

Presidential Address

FRANCIS H. LANGLEY, M.D.
ST. PETERSBURG

This is not New Year's Eve by the calendar, but it is in a very real sense to our Association. Our year is drawing to a close, and it is well to look back and think of the good things and the bad, the glories and the disappointments.

Two years ago I was entrusted with a great responsibility. It carried with it one of the greatest honors that could come to anyone—the trust and faith of his fellows. I had a year in which to train myself before the cares and duties of office really descended on me. With eagerness I followed the work of my predecessor, and constantly feared my own inadequacy; but as I watched the loyal support and strong backing of a united organization, my confidence grew. With such help, no one could fail.

A year ago John Milton passed the gavel to me. I received it humbly but with a burning determination to carry it honorably, and pass it on, having done my best.

As I look back through the years to my predecessors in the presidency, it seems that each in turn might join with the poet celebrating the torch bearers of knowledge, of integrity and of dedication to medicine and humanity.

Whispering, take this deathless torch of truth,
Take thou the splendor, carry it out of sight
Into the great new age I must not know,
Into the great new realm I must not tread.

Officers and Board of Governors

The Officers of the Association and the Board of Governors come first in this discussion. The dedication of these men deserves praise beyond my poor powers of expression. They have given careful consideration and wise counsel regarding the numerous problems which have arisen, and, I believe they have arrived at sound solutions of those problems. In doing so, they have sacrificed in time and money, and have done so cheerfully and gladly. Our Secretary-Treasurer, Dr. Samuel M. Day, has been most helpful, for many things are cleared through his office which would otherwise cause serious delay, and his continuing term of office gives him a profound knowledge of the working of the organization.

This year we have tried the use of an Executive Committee of the Board of Governors. The possibilities are still being explored, but it has served well in regard to long range planning. Several of the items which I shall discuss originated in this Committee, and many things are planned for the future.

Council

The Councilors under the leadership of Dr. Herschel G. Cole have done an exceptional job. The district meetings in the fall were well attended, and such was the care that went into their planning that I feel that any who did not attend were deprived of a fine experience. A new county society, Collier, has been established during the year. It is a small group but a most enthusiastic one. I am sure that the members will give us excellent support in all activities in their county.

Committee of Seventeen

At the request of Blue Shield, a committee of seventeen members was appointed as an advisory group to that organization. Two members from each councilor district were appointed with one member at large. Dr. Henry J. Babers Jr. has been chairman, and under his capable leadership great strides have been made in promoting better understanding between Blue Shield and our membership. Since we are Blue Shield, and this House of Delegates constitutes its governing body, it seems strange that such understanding is necessary. Problems, however, have arisen, though already many of them are being eliminated.

Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 5, 1957.

Scientific Work

Our Committee on Scientific Work, under the chairmanship of Dr. George T. Harrell Jr., has arranged a program which is varied and excellent. Our guest speakers are outstanding, and this meeting is an opportunity to learn much scientifically, as well as to acquaint ourselves with the activities of the Florida Medical Association.

Medical Postgraduate Course

As usual, the Committee on Medical Postgraduate Course is to be commended for the excellent program which it has provided. Not only was the Short Course well attended, but many took advantage of the five seminars throughout the year. These covered such varied subjects as cardiovascular diseases, gastroenterology, diabetes mellitus, cancer, and opthalmology and otolaryngology. I sincerely thank Dr. Turner Z. Cason and his co-workers.

Medical Education and Hospitals

The Committee on Medical Education and Hospitals has assumed new importance with the assignment by the House of Delegates a year ago of the duty of studying the relationship of Medical School Faculties and the Physicians of the Community. The actions of this Committee are detailed in its report, and they should be carefully studied as this is a matter of great importance, and one which has caused much antagonism in other parts of the country. Among other things, it recommended a Liaison Committee consisting of a member from each medical school, a physician from the county where each school is located, one from each medical district where there is no school, and a member at large. Dr. Walter E. Murphree, Chairman of the Committee on Medical Education and Hospitals, was appointed from Alachua County and made Chairman of the new committee also, in order better to integrate the two committees. I feel that they have done everything possible to avert future ill feeling and friction.

Medical Economics

The Committee on Medical Economics has continued work on malpractice insurance. Now that the state has allowed a 100 per cent increase in premiums, there is more interest in getting our business. The disability policy for our members has been written for many individuals. We are far short, however, of the percentage which would permit all members to participate regardless of physical condition. I hope that you will all think seriously of this coverage as it is excellent.

Legislation and Public Policy

The Committee on Legislation and Public Policy under Dr. H. Phillip Hampton has been working steadily throughout the year. Its task is never ending as new problems arise faster than the old ones can be disposed of. Yet, the thought and care which the members of this Committee expend deserve from every member of the Association the support which we alone can give, in contacting our legislators and other people in position to help us.

To all chairmen and committee members I wish to express my heartfelt thanks. Time does not permit my dwelling on each committee by name, but they have all done well. I urge you to read each of the reports in detail as they cover the year's work for the Association. Such study will help you to evaluate the work of the Association and give you some idea of the immense amount of effort expended by our membership.

Medicare Program

I shall pass quickly over the Medicare Program as it will be reported by Dr. Milton. In June 1956, the Congress passed legislation requiring the care of all military dependents, either at military installations or by private physicians. Six months were allowed to implement the program. This was an almost impossibly short interval, but the American Medical Association and the Department of the Army went to work with representatives of the state associations. As you recall, we had a called meeting in November when there was much dissatisfaction expressed. Yet we had no recourse, and our representatives were empowered to bargain in our behalf. We may be proud that our schedule is reported as the best of any state. For this I am glad to express my thanks to Dr. Milton. He carried the burden of the negotiations, though he had the assistance of a fine committee on his original work. Blue Shield was set up as our fiscal agent. So far, the situation has not developed too many problems.

In anticipation of renegotiation of our contract, you instructed me to set up a Fee Schedule Committee of fifteen men in five categories to work out a more carefully balanced fee schedule. This has been done, and they have entered into the work with enthusiasm. I understand, however, that the time for renegotiation has been

changed from June 1957 to early 1958, as it was thought that necessary data would not be available. To avoid misunderstandings, an arbitration committee has been arranged to try to smooth out situations not completely covered in the established rate schedule.

Budget

Our budget has been worked out for the coming year, and just as in the past year, there should be a definite margin of savings. Our expenses rise, but so does our income, and at present we are on sound ground. The report of the annual audit will be published in the July Journal.

Public Relations

Dr. Edward Jelks continues as Liaison for the Board of Governors with our Public Relations organization. To this important work he brings a remarkable experience in the practice of medicine. One has the conviction that in time of stress, here is a man who can always be relied upon for understanding and sound advice. The quality of his work is a goal we should all strive to emulate.

The Association had a very attractive exhibit at the Florida State Fair in Tampa under the supervision of Mr. Eugene L. Nixon. I watched it for a time, and real interest was displayed in it by the public.

At the State Science Fair in Gainesville, our Association offered prizes in the junior and senior divisions for exhibits in fields allied to medicine. The exhibits came from local fairs all over the state and they were wonderful. Our judges became very enthusiastic, and I am confident that this activity can well be maintained, and even enlarged.

New Association Building

On the fifteenth of September 1956, the new Home of the Association was dedicated. We all had anticipated this for over a year, but the reality far surpassed our hopes. The building is beautiful and practical. Our staff can now work to advantage, and it is surprising how much more use is made of the building by various committees than we had expected. Our thanks are due to the committee who carried this project through, Drs. Edward Jelks, Robert B. McIver and Samuel M. Day. You will be happy to learn that it was possible to complete and furnish the building without going in debt. In fact, we had a small surplus.

Executive Staff

As the Association grows, there is an increasing load placed on the staff of our Executive Office. The major problems and the minutiae of detail alike keep them under constant pressure. At all times our Managing Director, Mr. Ernest R. Gibson, has his finger on the pulse of our work. His quiet efficient management makes everything so smooth that one has to remember that such service does not just happen.

Mr. W. Harold Parham is Assistant to Mr. Gibson and Supervisor of the Bureau of Public Relations. He is intimately acquainted with the work of the Association and particularly as it applies to our relationships with others. A diplomat of the first order, he is a power to be reckoned with in all his activities.

Mr. Nixon is building a fine place for himself in the organization. More and more, important duties are being entrusted to him, and he performs them well.

Our thanks are due for the devoted work of Mr. Thomas R. Jarvis, Director of Publications; Mrs. Zoe Pack, Office Manager; Mrs. Mae W. Mason, Secretary to the Board, and the remainder of our hard-working staff.

Thirty-Five Year Certificates

We have considered for some time at the Board meetings the desirability of some recognition for long service in the practice of medicine in Florida. The question of honoring our fifty year members was given up as being too long a span for most of us to attain. We have life membership for those who have been active members for thirty-five years. This is fine, but it was thought that further recognition in the shape of a certificate to be presented to each member at the convention following his attaining life membership would be in order. The Board approved the idea and the certificates have been prepared and will be presented during this meeting. On the ninth of April, I was privileged to present the first certificate to Dr. Joseph Halton, of Sarasota, at a meeting of the Sarasota County Medical Society, given over to recognition of his fifty years of active practice in Sarasota. He brings to six the number of our fifty year members.

Convention Schedule

As you have noted, there has been a reorganization of the convention schedule. Various rea-

sons have necessitated this. One of the most important was the need to provide more time for our all important reference committees. So much business has to be transacted that it must be carefully considered, with an opportunity for all interested parties to be heard, by such small groups. Their careful recommendations are then heard by the House and usually are accepted. Such trust required that their deliberations must not be hurried.

Also, this House is the Governing Body for Blue Shield and adequate time had to be found for the Annual Meeting. Now the newly seated group of delegates will hold the meeting rather than the outgoing one. I believe that this change will unite us more closely behind Blue Shield and trust each delegate will be at the meeting tomorrow.

Auxiliary

As we have come to expect, our Auxiliary has done a magnificent job this year. My sincere congratulations to the President, Mrs. Scottie J. Wilson, and her able group of officers and committee women. I believe that I should also commend Mrs. Richard F. Stover for her work in getting the Charter, Constitution, and By-Laws in order. To all the ladies, I extend my sincere thanks for their constant help, and to Mrs. Perry D. Melvin my best wishes for a successful year to come.

A. M. A. Delegates

We have in our midst a group of men who are working hard, not just this year, but through the years in behalf of our own State Organization and for the Profession as a whole. I refer to our Delegates to the American Medical Association, Drs. Louis M. Orr, Reuben B. Chrisman Jr. and Francis T. Holland. Their work is outstanding as is that of Dr. Homer L. Pearson Jr., who is Chairman of the Judical Council of the A. M. A.

Florida Medical Foundation

The establishment of the Florida Medical Foundation was authorized by the House of Delegates a year ago. The organization has now been completed. Our Charter has been issued and Constitution and By-Laws adopted. The governing body is the Board of Governors of the Florida Medical Association, and the officers are Dr. Edward Jelks, President; Dr. John D. Milton, Vice President; and Dr. Clyde O. Anderson, Secretary-Treasurer. Although the organization has recently been completed, there is already a small sum of money in the treasury. I hope that very soon this will be multiplied to the point that work on varying lines may be started.

Constitution and By-Laws

It has become increasingly evident that the Association's Constitution and By-Laws are long overdue for a thorough revision. Continuous amending over the years has permitted discrepancies and even contradictions to creep in. I recommend that the President be instructed to appoint a subcommittee to the Board of Governors, to study and rewrite the Constitution and By-Laws, and present them to the House of Delegates at the next annual meeting for consideration.

Sound and effective revision will be no easy task. Many phases of Association activities will require extensive study to determine what changes are required now, and for the years ahead. The Journal, for example, has grown and prospered splendidly and has kept pace with progress, but it has done so under increasing handicaps. The time has come to give its organization, procedures and policies careful scrutiny to determine how it can best serve the Association.

This problem has been discussed with the Editor, Dr. Shaler Richardson, who is in full accord with my recommendation that the President be instructed to appoint a committee of not more than five members to consult with the Editor in a study of all phases of The Journal and to report its findings and recommendations at the next annual meeting of the House of Delegates. These could then be incorporated in the Constitution and By-Laws, thus relieving the other committee of this particular topic.

When we think of such a wonderful publication as our Journal, I am sure that everyone will wish to do all possible to make things easier for the Editor, Dr. Richardson, and his Professional Staff. At the same time, we can show our commendation of Mr. Jarvis and Mrs. Edith B. Hill, who have worked so enthusiastically for The Journal, by simplifying some of their problems.

I believe that this covers the major happenings of the year. Considering the number of people working, I could spend hours detailing the many fine accomplishments of our individual committees, county societies, county officers, indeed all who unselfishly give of their time and labor for the good of all.



Dr. Francis H. Langley delivering Presidential Address.

Union and Solidarity

A year ago, Dr. Milton spoke of the dangers of the corporate practice of medicine. This is a constant threat to American Medicine and is rapidly increasing as a threat here in Florida. New industries are pouring into the state, and the unions are demanding more and more concessions. Much thought and careful planning must be expended if we are to meet this challenge to the private practice of medicine. The keystone of private practice is the physician-patient relationship. This calls for the free choice of physician by patient, as well as the right of the physician to decline the care of a patient whom he does not wish to treat.

The closed panel is the device of those who wish to subordinate the physician to some outside group. Their motto is "Divide and Conquer," and this is a method which has been used disastrously throughout all recorded history by tyrants and dictators. The United States of America early recognized the dangers inherent in this approach and set up a tightly knit union instead of a loose federation of states. Do you have a coin in your pocket? If so, you will find on it two rules for guidance of a nation such as ours, or an association such as ours. The first is "In God We Trust." No one will gainsay this noble rule by which we all try to live. On the other side of the coin we find in Latin "E Pluribus Unum." "One from many." Here is the critical point. We must present a united front. A saying learned in childhood "United We Stand, Divided We Fall" was never more true than now.

It has been with great anxiety that I have observed a tendency on the part of a few to be ready to disrupt the unity of the profession. It is manifest in threats to carry to the newspapers stories of dissension and disagreement, and in willingness to sign on closed panel insurance lists in the hope of personal advantages, not recognizing that by so doing, one gives power to those who would debase and degrade the practice of medicine.

I quote from an address by G. Westbrook Murphy, M.D., of Asheville, N. C.: "We live in a society which is largely controlled by tightly organized groups, and I submit to you the hypothesis that in it only an organized group can survive. In the eyes of the public we are a union. We bear the excoriation and censure which is often heaped upon unions, but we have not had the advantages which come from union organization. I do not suggest that now or ever in the future we refuse to give our best professional services to

all the sick who need us. I do suggest that we use the power of this organization to control the social and economic circumstances under which our services are rendered when a third party intervenes between physician and patient."

George Washington once said: "If to please the people, we offer what we ourselves disapprove, how can we afterward defend our work? Let's raise our standard to which the wise and honest can repair—the event is in the hand of God."

Dr. Samuel Z. Freedman, President of the New York County Medical Society, makes the suggestion that physicians do their negotiating with labor unions, management, insurance companies and hospitals through their medical society. I quote: "The practitioner of medicine as an individual is at the mercy of any group which decides to provide medical care through a closed panel system, a clinic, or any other plan in which the physician becomes a hired hand."

Now a final quotation from that great American whose knowledge and understanding of people have probably never been equaled, Benjamin Franklin: "They that can give up essential liberty to obtain a little temporary safety deserve neither liberty nor safety."

Before I close, I wish to thank my wife Sarah, who has been a constant help and inspiration to me. I know that I have tried her patience on many occasions, but it could not be avoided. Her company on some trips made them vastly pleasant, and I hope she enjoyed them as much as I. To my children, I am sorry that I disrupted many of their plans. I promise to do better in the future.

I spoke of the torch bearers at the opening of this address—the men who have been Presidents of this great Association. Before me I see succeeding Presidents, though I know not which ones they are; and still beyond them are others still in school, even as yet unborn. So I must return to the poet and say:

Come then, swift footed, let me see you stand
Waiting before me, crowned with youth and joy;
This is the turning. Take it from my hand.
For I am ready, ready now, to fall.

National Socioeconomic Issues Confronting Medicine

ERNEST B. HOWARD, M.D.
CHICAGO

Political-Legislative Situation

At the moment the Washington legislative situation can be characterized as moving in a sidewise direction. Many health bills have been introduced, but little significant action has occurred because of the preoccupation of the Congress with the subject of government economy. If the economy drive succeeds in bringing about a significant reduction in the budget, many health bills that might have received favorable attention will die in committee.

It is our hope that substantial reductions will be made in government appropriations. Such reductions would make unlikely the adoption of health measures opposed by American medicine.

The Eisenhower administration, notwithstanding its relatively liberal proposals in certain directions, is not supporting any important health legislation in this Congress to which the American Medical Association objects. It is significant that for the first time in many years no special health message was delivered to the Congress. The absence of a health message reflected the attitude that no health crisis exists.

Only two health proposals are receiving serious administration consideration: (1) federal support on a one time basis of reconstruction and renovation of the physical plant of medical schools, and (2) legislation to permit pooling of insurance funds for the purpose of selling substandard or high risk health insurance without violation of the antitrust provisions of the Sherman Act. The AMA has repeatedly endorsed the Hill-Burton type of program for renovation and reconstruction of medical schools proposed by the administration. No stand has been taken relative to the pooling of insurance funds by the health insurance industry, and it is unlikely that the Association will adopt any position on this issue.

Social Security

The administration's attitude toward the disability amendments to the Social Security Act adopted in 1956 has not, so far as we know, changed. This amendment, providing cash bene-

Assistant Secretary, American Medical Association.
Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 6, 1957.

fits at age 50 to Social Security enrolees who are disabled as defined in the bill, was strongly opposed by Secretary Folsom of the Department of Health, Education, and Welfare on behalf of the Eisenhower administration, at the Senate Finance Committee hearings in 1956. Notwithstanding the opposition of the AMA, the U. S. Chamber of Commerce, the Farm Bureau Federation, the health insurance industry, and the administration, the bill was adopted 47 to 45. It was a bitter defeat, and it set the stage for an expanding role of the federal government in medical care. Already bills have been introduced to liberalize the disability definition, reduce the age at which benefits can be received, add "free" hospitalization to Social Security beneficiaries over the age of 65 and increase the taxable income limit from $4,200 to $6,000. Through this disability provision the drive for compulsory health insurance has been facilitated.

Specific Legislation

VA Medicine.—Certain bills have been introduced in the field of veterans' medical care that provide a ray of hope in that they tighten the requirements for eligility for such care. On the other hand, pressure continues for liberalizing governmental benefits to veterans and their dependents. Of all AMA legislative programs none requires more vigilance and patience, for the veterans' medical care program has been in operation for a long time. Every medical society and physician should support Dr. Louis Orr, Chairman of the AMA Committee on Federal Medical Services, in his statesman-like efforts to contain this program and eventually bring about changes in the basic legislation that will establish it on a sound basis.

Social Security Coverage of Physicians.—Coverage under the Social Security Act still excludes physicians. There is at the present time no strong pressure in the Congress for their inclusion. I would be less than candid, however, if I did not admit that there appears to be a growing percentage of physicians who desire compulsory coverage and who have been increasing their pressure within the organization for a change in our fundamental policy. The information that we have indicates that physicians in general are still overwhelmingly opposed to compulsory coverage, but the percentage of such opposition has declined.

A vigorous program is being pushed to promote passage of the Jenkins-Keogh bills. These bills will permit physicians and other self-employed persons to set aside from current income a maximum of $5,000 or 10 per cent, whichever is lower, into an individual retirement trust fund. The fund could be established through insurance companies or banks. Taxes on the current contributions would be deferred until the money was withdrawn at the age of 65 from the fund. The American Bar Association and many other organizations, including the AMA, have combined their resources in the American Thrift Assembly, which is conducting a vigorous campaign of information and education on this issue. Unfortunately, other groups are seeking special benefits which may make the Keogh-Jenkins proposals more difficult to achieve. The railway employees are seeking tax deductibility for their contributions to their government-controlled pension fund, and there is pressure for the granting of tax deductibility for the contributions of Social Security taxpayers. The Keogh-Jenkins principle, therefore, which is equitable for the self-employed, is being exploited by other groups in such a way as to endanger the success of the entire program.

Medicare.—The Medicare program which has now been in operation for some time has obviously become a serious issue at this meeting of the Florida Medical Association. The central issue is the degree of control, if any, that should be exercised by the federal government over the fees charged by physicians for the treatment of dependents of service men. In the negotiations conducted by the AMA with the Department of Defense, it was held by the Department of Defense Task Force that the intent of the Congress was that a full service program be set up. The Task Force further insisted that a schedule of allowances, constituting full payment, must be a part of such a program.

Whatever the interpretation of the Department of Defense, and the U. S. Army office that acts as its agent, the law itself does not require any schedule of allowances.

Contract Practice

Contract practice, in which physicians are hired by third parties for the purpose of providing medical services on a prepayment basis or on fee-for-service received by the third party, has always caused deep concern among medical societies. It is obvious that when medical services are provided by a third party, particularly of a corporate nature, the opportunity exists for ex-

ploitation of the physician and the public by the sale of medical services primarily for profit. The abridgment of the right of the patient to select the physician of his choice that characterizes many medical care plans of the contract or corporate type is what most disturbs the medical profession. This basic principle of "free choice" is the essence of capitalism. It is the case of antisocialist philosophy. In this sense, therefore, it applies to all free, competitive enterprise as well as to the provision of medical care.

The second basic free enterprise principle that applies to medicine, as well as to other professions, commerce and industry, is the right to seek a fair price for service rendered. Interference with this right is common in contract or corporate practice. The medical profession properly looks with a jaundiced eye on the loss of this privilege.

The corporate practice of medicine by hospitals, medical schools, lay-sponsored plans and other agencies continues in a state of flux, expanding in some areas, receding in others. The Larson Commission on Medical Care Plans of the AMA is conducting an exhaustive study of many of the problems incident to this type of medical care. Undoubtedly it will report conclusions of far reaching importance in the near future to the AMA House of Delegates.

Labor

The future shape of medical practice will depend to a considerable degree on what the AFL-CIO finally decides to do in the field of health. Unlike its attitude on pensions, the AFL-CIO has not yet crystallized its position on medical care. Bargaining for health benefits, therefore, is characterized by diversity rather than by uniformity. If the AFL-CIO continues its support of compulsory health insurance and the promotion of medical care plans characterized by full service, fixed fees, closed panels, no income limit, medicine's troubles will be compounded—for the political and economic power of labor must not be underestimated.

In this connection, the current McClellan committee investigation of racketeering and corruption in labor is a salutary event. It will undoubtedly have a profound effect upon the activities of labor. It is unlikely, however, that it will neutralize the effect of labor on the practice of medicine. Under the circumstances, it is urgently necessary that medicine use all of its resources to inform labor leaders about the practice of medicine and the nature of the physician-patient relationship. It is possible—although unlikely—that we can persuade labor to withdraw from its position of supporting compulsory health insurance.

Collaboration with Other National Organizations

Medicine cannot win its battle alone. It is vital that American medicine collaborate as closely as possible with other national conservative organizations. Nationally, we have succeeded in the last few years in establishing constructive relations with the U. S. Chamber of Commerce, the National Association of Manufacturers, the American Farm Bureau Federation, the National Retailers Federation, the American Bar Association and many other professional and business groups. These relationships have been fruitful both for medicine and for the nonmedical leaders with whom we have consulted. I urge you to expand this liaison so that it exists in the states and counties wherever appropriate liaison can be established.

Conclusion

It is just as difficult to prognosticate socioeconomic events as it is in difficult medical cases. Obviously, a serious struggle is now in process between the conservative and liberal wings of both major parties. The present economy wave, if it is brought to a successful conclusion, will be a strong force for conservatism. The spontaneity and widely diffused nature of the public's reaction to high taxes and government spending are enormously encouraging. Other factors, such as the increasing percentage of home ownership, the movement of families from crowded urban areas into the suburbs, the recent strong antisocialist comments of the father of "cradle to the grave" security, Lord Beveridge, and many other isolated events, suggest a possible renaissance of conservative thought and action. Certainly it can be said without fear of contradiction that a spirit of defeatism will lead to nothing but defeat. A reasonable degree of hope and optimism is essential if we are to stem the tide of government control. One of the most effective tactics used for years by socialist propagandists has been the promotion of the idea that socialism is inevitable. We must as a countertactic oppose this false idea at every opportunity, and press every advantage we have—for tomorrow's history will be written by leaders with courage and conviction, not by those who have already yielded.

535 North Dearborn Street 10.

Dependents' Medical Care Program

Lt. Col. E. G. Rivas, MSC
WASHINGTON, D. C.

It is an honor and a privilege to speak to you today concerning the Dependents' Medical Care Program. Before I discuss the program, however, I want you to know how very much we appreciate the wonderful manner in which you have cooperated with us in its implementation and execution. We think that everyone has done a magnificent job. Before coming here, I carefully looked over our files concerning the operation of the program in Florida. I found no correspondence which indicated that any serious problem existed in the administration of the program in this state. On the contrary, it seems to be operating in a highly efficient manner.

Florida ranks third in the nation in the number of cases of dependents cared for under the Dependents' Medical Care Program. Perhaps you have guessed that your record is topped only by your age-old rivals, California and Texas. Approximately 4.8 per cent of all claims received have come from the state of Florida.

Program Experience

To date, we have received approximately 88,000 hospital and physicians' claims amounting to about $7,000,000. Some 37,000 of these claims are from hospitals while about 51,000 have been received from physicians. The average cost per claim for physicians amounts to approximately $68 while the average cost for a hospital claim is around $96. These figures do not include administrative costs connected with the handling of claims.

You might be interested in knowing that 41 per cent of all claims received were for care rendered to Air Force dependents; 31 per cent for Navy; 26 per cent for Army; and 2 per cent for public health service. I am not sure that these statistics prove anything. It is noteworthy, however, that dependents of Air Force personnel lead the list of those eligible dependents benefiting from care authorized from civilian sources. Another interesting point is that 42 per cent of all claims received involve the care of dependents who reside away from their sponsors, that is, those who in the past have received care from civilian sources at their expense.

Analysis of Statistics Concerning the Program

Although it is a little early in the program to present statistical data connected with the program, or to attempt to evaluate collected statistics, we have made an analysis of claims so far submitted, which I should like to offer to you for your information.

Principal Procedures and Operations From 5,000 Physicians' Claims

Operation or Procedure	Per Cent	
Physician's Visits		23.4
Hospital visits	18.1	
Home or office visit	5.3	
Surgery		73.0
Maternity	37.9	
Delivery	28.8	
Miscarriages and abortions	3.7	
Circumcisions	2.7	
Cesarean	1.8	
Others	0.9	
Female genital system	8.0	
Curettage of uterus	3.1	
Hysterectomy	1.7	
Salpingectomy	0.7	
Oophorectomy	0.6	
Others	1.9	
Eye, ear, nose, throat	18.0	
Tonsillectomy	17.4	
Eye	0.2	
Ear	0.2	
Nose	0.2	
Abdominal operations	4.6	
Appendectomy	1.8	
Herniorrhaphy	1.4	
Hemorrhoidectomy	0.4	
Cholecystectomy	0.4	
Others	0.6	
Integumentary system	2.2	
Musculoskeletal system	0.9	
Other operations	1.4	
Other Procedures		3.6
Pathological examinations	2.5	
X-rays, diagnostic	1.1	
Total		100.0

Source: ODMC claims from physicians.
Date: March 1957.

Identification of Dependents (Eligibility Card)

The dead line date for which dependents must have in their possession an identification card entitling them to care under the program has been extended to Dec. 31, 1957. This extension was necessitated by difficulty in preparing a suitable card to be used in connection with the program.

Director, Liaison and Special Activities, Office for Dependents' Medical Care, Office of the Surgeon General, Department of the Army.

Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 5, 1957.

I am happy to say that this card has now been decided upon and is being printed. It should be available in the field in the immediate future.* A card will be required in the case of all dependents 10 years of age and over. A picture of the dependent will be required. While, as I mentioned before, the dead line has been extended to Dec. 31, 1957, it is hoped that every eligible dependent will make an effort to obtain an identification card as soon as possible.

Comment on Questionnaires

Our office sent out a number of questionnaires to dependents who availed themselves of care from civilian sources under our program. Without exception, all stated they were entirely satisfied with the care they received. Many were most complimentary in their replies concerning care which they received from civilian sources. This is certainly a tribute to the practice of medicine in this country.

*DD Form—1173 is now being issued.

Summary

In summary, I should like to say that the program is operating in a highly commendable manner. We have received extremely few complaints of any nature, and those we have received have not been concerned with the quality of care, but rather with the lack of coverage provided by the program, particularly in the area of outpatient care. I do not know of one single instance in which a physician has denied an eligible dependent care under the program.

Again, I wish to thank all of you for contributing so much to the operation of the program—the physicians for their participation in caring for our dependents; the Florida Medical Association for its invaluable assistance in the implementation and continuing operation of the program in Florida; and the fiscal agent, Blue Shield of Florida, Inc., for handling so efficiently the payment of physicians in this state.

ABSTRACTS

Hemicrania — or One-Sided Sphenopalatine Ethmoid Headache. By Wm. H. Turnley, M.D. Laryngoscope 66:582-591 (May) 1956.

Hemicrania, a term first adopted by Galen and eventually corrupted to migraine, designates a one-sided headache which seems to have its origin in the sphenopalatine ganglion region of the nose, between the posterior ethmoid cells and the nasal septum. The syndrome may radiate from this spot to the entire side of the body in extreme cases, simulating the whole gamut of headaches from tic to epilepsy. The author here relates his experience in treating this type of headache, discussing the anatomic considerations, symptoms, signs and therapy. He comments on the much greater frequency with which he has encountered this syndrome in central Florida than in a metropolitan area in the North. His clinical results have convinced him that the treatment "par excellence" is relieving the pressure and allowing ventilation and drainage in the sphenopalatine ethmoid area by a careful and thorough submucous resection of the nasal septal cartilage, especially posteriorly and superiorly, although even this is not a panacea.

Postdiphtheritic Polyneuritis and Pseudodiphtheritic Polyneuritis: Report of Two Cases Treated with Cortisone and Corticotropin. By H. J. Roberts, M.D. A. M. A. Arch. Int. Med. 97:618-626 (May) 1956.

Two cases are reported in which cortisone and corticotropin were employed in the treatment of diphtheritic and pseudodiphtheritic polyneuritis, primarily because of the progressively deteriorating state of the patients. In one patient with atypical diphtheritic polyneuritis these hormones neither reversed nor retarded the neuritis and cardiac complications. The treatment, however, had been delayed by one month following the initial pharyngitis. The other patient, manifesting a progressive neuritis, exhibited a dramatic and complete remission when cortisone was begun, approximately three weeks after the faucial inflammation and two weeks after she had ingested apiol. The diphtheria organism was not cultured, although penicillin and antitoxin therapy had already been administered. The differential diagnosis of this case is discussed. The available literature relating to the use of cortisone and corticotropin in diphtheria and polyneuritis is reviewed,

"Opinion evidence, as a whole, is not looked on with great favor by the law. It is probable that juries are more prone to distrust the testimony of the medical expert witness than the testimony of any other witness. Laymen find it difficult to understand how honest physicians may express contradictory opinions. Jurors do not at times seem to attach any higher credibility to the testimony of physicians of high standing than to that given by the 'professional' expert witness. . . .

"Although medicine is not an exact science and although it is the opinion of the expert witness that is generally of primary importance, it is believed that in most instances a panel of impartial medical experts would be able to find basic agreement and that their conclusions would reflect the truth that the court and the jury seek."[6]

Appointment by the court of medical experts, whose services are paid for usually by the defense in the first instance, is still another way to secure unbiased expert medical advice. This method is now widely used.

Need for a New Order

On May 22, 1956, Dr. Walter C. Alvarez,[7] through his syndicated column "How to Live," made astute observations on "The Need for Impartial Medical Expert Testimony." He declared that for 45 years he had seen the need for a new order and warmly endorsed "Impartial Medical Testimony,"[8] a book just published by The Macmillan Company. This book is recommended reading for every physician, lawyer and jurist in America. The New York Medical Expert Testimony Project described in the book has been in operation since 1952 in New York City, with the New York Academy of Medicine and the New York County Medical Society designating the medical talent, and has been "adopted as a regular part of the operations of the Supreme Court of the State of New York in the First Department." The basic idea of the Project revolves around panels of "neutral outstanding physicians in various specialized branches of medicine." Available at the call of the court, these experts make medical examinations of plaintiffs in personal injury cases, report their findings, and, if necessary, testify in those cases in which medical aspects are controversial and substantial. These unquestionably expert members of the medical profession, Dr. Alvarez noted, do not have to depend for their remuneration on either the prosecution or the defense. Their fees are charged against Project funds. Such panels, he observed, make trials much more dignified with less hysteria and more good sense. In addition, trials have thereby been shortened, a result that is particularly gratifying since approximately 80 per cent of the cases in trial courts of the country are personal injury cases, involving the taking of medical testimony, and courts are often years behind in their work.

As the title of the book indicates, the new order seeks the antithesis of partisan medical testimony as now too frequently practiced by a considerable group of lawyers and doctors who do not conform to the highest traditions of their calling. An impartial expert gives confidence to judge and jury in understanding the technical aspects of a problem. Although the legal and medical professions have made efforts to curb abuses in the presentation of medical proof, "this Project represents the first major effort in the personal injury field to cope with the problem by arming the judge with facilities as well as power to appoint neutral, competent medical experts."

Interestingly enough, Professor Delmar Karlen of the Institute of Judicial Administration of the New York University Law Center, as research director, and Dr. Irving S. Wright, Professor of Clinical Medicine at the Cornell Medical College, as medical consultant for the Project, reached substantially the same conclusions, the one from the legal and the other from the medical viewpoint, in their independently written reports. They and the other members of the Committee on the Medical Expert Testimony Project, reporting after a highly successful two year trial of this pilot project, cited the following accomplishments:

"1. The Project has improved the process of finding medical facts in litigated cases.

"2. It has helped to relieve court congestion.

"3. It has had a wholesome prophylactic effect upon the formulation and presentation of medical testimony in court.

"4. It has proved that the modest expenditure involved effects a large saving and economy in court operations.

"5. It has pointed the way to better diagnosis in the field of traumatic medicine. Unlike the others listed above, this accomplishment is an unexpected dividend, which was not in contemplation when the Project was initiated."

Conclusions

The great majority of cases in trial courts are personal injury cases, requiring the taking of medical testimony.

The average doctor is inadequately prepared for and dislikes to appear in court.

The time is propitious for both the medical and the legal professions to clear themselves of any suspicion of bias and prejudice in the mind of the public and to renew efforts to secure only the truth.

To obtain unbiased nonprejudicial medical expert testimony in personal injury cases, a system based on the New York Medical Expert Testimony Project described in "Impartial Medical Testimony" is recommended.

Such medicolegal collaboration offers the best remedy yet proposed for the deficiencies and abuses prevailing in the presentation of medical proof in judicial proceedings by enlisting the services of independent and impartial medical experts to aid the court in the better and quicker disposition of those cases which are most voluminous in the courts of this country.

An outstanding example of successful interprofessional cooperation, the Project charts the way toward a new order which offers a solution to the universal problem of securing better medical testimony, not alone in personal injury cases but also in other types of litigation in which the physical or mental condition of a litigant may be involved. This approach improves the administration of justice, upholds the best traditions of the medical and the legal professions and promotes favorable public relations.

Appreciation is expressed to the many members of The Jacksonville Bar Association who gave helpful guidance in the preparation of this paper.

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225 West Ashley Street.

Determining Immunity Level in a County

JOSEPH W. LAWRENCE, M.D.
ARCADIA

In November and December of 1955, there was a mild epidemic of diphtheria in DeSoto County. In a total of 12 cases, all of the patients were white, and fortunately, all but one recovered without any apparent sequelae; in the one case the disease was fulminating in type, and the patient died. Because of the public alarm at that time, the staff of the DeSoto County Health Center gave a markedly increased number of immunizations for the months of November and December. In November, we gave 288 diphtheria inoculations, 143 being given to children five years of age or older. In December, we gave 370 diphtheria inoculations, 329 being given to children five years of age or older. During these two months only eight smallpox vaccinations were given. For the entire year of 1955, there were 863 diphtheria inoculations given in the DeSoto County Health Center, and 658, or 76 per cent, of these were given during November and December. Needless to say, as soon as the public lost its fear, the rate of inoculations immediately dropped drastically; in January 1956 there were 88 and in February only 28. These figures are from the records of the Health Department only and include no inoculations given by the practicing physicians of this county. They fairly well reflect the immunity in the community, however, as we give about two thirds of the inoculations in the county.

Because of this epidemic and the resultant mass inoculations, Dr. L. L. Parks, Director of the Bureau of Special Health Services, thought that it might be interesting to attempt to determine the immunity level in the county. It is true that "fools walk in where angels fear to tread," as I aptly demonstrated by deciding to make a survey in all three of my counties, comprising the DeSoto-Hardee-Charlotte Health Unit, rather than in just one county. Had I realized the amount of work involved, I assuredly would not have

Director of the DeSoto-Hardee-Charlotte Health Unit.
Read before the Florida Health Officers' Society, Eleventh Annual Meeting, Miami Beach, May 13, 1956.

and it is suggested that serious consideration be given to the employment of these agents in patients with progressive polyneuritis, particularly when bulbar symptoms are present and the etiology is obscure. It is stressed that the definitive place of hormonal therapy instituted early in diphtheritic polyneuritis has yet to be evaluated.

Histochemical Studies in Squamous Carcinoma. By Alvan G. Foraker, M.D. Cancer 9:367-373 (March-April) 1956.

In the study reported here 38 examples of primary squamous carcinoma of the skin or mucosa or of metastatic squamous carcinoma were subjected to a battery of histochemical technics, including localization of dehydrogenase, alkaline phosphatase, phosphamidase, protein-bound sulfhydryl and disulfide groups, and glycogen. Comparisons were made with epidermis and squamous mucosa. In general, squamous carcinoma showed a reaction pattern similar to that of deeper layers of epidermis or mucosa, including evidence of dehydrogenase and phosphamidase activity. Keratinizing squamous cells from neoplastic and non-neoplastic epithelium contained disulfide groups. Squamous cells in superficial layers of epidermis and mucosa and well differentiated squamous carcinoma cells contained glycogen. No histochemical reaction pattern peculiar to carcinoma was found.

Vascular and Allergic Headaches; A Panel Discussion. By French K. Hansel, M.D., Raymond L. Hilsinger, M.D., Bernard M. Barrett, M.D. Tr. Am. Acad. Ophth. 60:459-464 (May-June) 1956.

In this panel discussion, Dr. Hansel describes vascular headache, and Dr. Hilsinger discusses the treatment of this type of headache. Dr. Barrett discusses the resistant headache patterns which persist regardless of etiologic evaluation and proper therapy. He reports a series of cases classified on the basis of vascularity in which reserpine therapy was used as an adjunct in the treatment of the various resistant headache patterns which had not responded to any other form of treatment. Included were cases of migraine, "histaminic cephalalgia" and those classified as of the carotid type or atypical as well as those due to vascular tension. He concluded that reserpine merits consideration in the treatment of these resistant cases.

A New Rapid Detection Method for Gastric Cancer: The Rotating Gastric Brush. By J. Ernest Ayre, M.D. Acta Union Internationale Contre le Cancer 12:13-19, 1956.

The rotating gastric brush is described as a new rapid method for diagnosis of gastric cancer. The method is a simple, relatively painless procedure, suitable for use in the physician's office, and it, therefore, lends itself well to mass use. Extensive trials have included tests on several hundred patients, and the present report includes the follow-up on a consecutive series of 339 of these. The accuracy of the brush procedure appears to compare most favorably with other diagnostic methods. It is particularly significant that false negative errors have been rare; in all cases of proved cancer except two, positive or suspicious cells were recognized. In no case was there evidence of hemorrhage in this series, which included normal persons, patients with gastric ulcer and patients with malignant lesions.

Massive Hemorrhage into an Adrenal Pheochromocytoma, Report of a Case with Sudden Death. By David J. Lehman, Jr., M.D., and Jack Rosof, Ph.D., M.D. New England J. Med. 254:474-476 (March 8) 1956.

Irreversible shock and sudden death due to massive unilateral adrenal hemorrhage without sepsis is a unique, often unrecognized syndrome, death usually being ascribed to some other catastrophic illness. The case reported here illustrates the diagnostic difficulties that may be encountered. In this case it was established at autopsy that there was a hemorrhage into a previously unsuspected pheochromocytoma. It is concluded that a high index of suspicion is necessary for the correct diagnosis of a case of acute collapse and pulmonary edema occurring with unilateral adrenal apoplexy. This type of case is regarded as a definite clinical syndrome that may prove to be remediable if early diagnosis is made and treatment instituted.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.






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Proceedings
Eighty-Third Annual Meeting

Florida Medical Association
Hollywood, May 5-8, 1957

GENERAL SESSION

The Eighty-Third Annual Meeting of the Florida Medical Association was called to order at 9:30 a.m., Monday, May 6, in the Pageant Room of the Hollywood Beach Hotel, Hollywood, Florida, by President Francis H. Langley.

Invocation was pronounced by The Reverend S. Harry Russell, of the West Hollywood Methodist Church, Hollywood.

Dr. Langley introduced Dr. Walter J. Glenn Jr., of Fort Lauderdale, President of the Broward County Medical Association.

Dr. Glenn: "Mr. President, Members of the Florida Medical Association:

"It is a distinct privilege and pleasure to speak for the Broward County Medical Association in welcoming the Florida Medical Association for its Eighty-Third Annual Convention. We, as individuals and as a group, have attempted to make available facilities which will be adequate to insure success. Individual members of our county association will be glad to assist their fellow members of the Florida Medical Association, or you may contact the members of the committees listed in the program for assistance in finding any diversions you may wish. Feel free to approach any of our members whenever you desire assistance. We hope that you enjoy your stay here and that the experience will prove rewarding in direct proportion to the efforts of many to make this convention possible."

Dr. Langley: "Are there any fraternal delegates from other states?"

Dr. Charles E. Merkert from Minneapolis, Minnesota, was welcomed to the meeting.

Dr. Langley: "We are delighted to have with us today Dr. Ernest B. Howard, Assistant Secretary of the American Medical Association. Dr. Howard received his M.D. degree from Boston University Medical School and Master of Public Health degree from the Harvard School of Public Health. He served with the Massachusetts Department of Public Health from 1940 to 1942 and as assistant director of the Army's V. D. Control program from 1942 to 1945. He was chosen as chief of the U. S. Department of State's health mission to Peru in 1946. He joined the A.M.A. as Assistant Secretary in April, 1948. Dr. Howard will speak to us on 'National Socio-Economic Issues Confronting Medicine.'"

(Dr. Howard's address appears in this issue of The Journal on page 24.)

Dr. Langley: "It is with great pride that I introduce my guest speaker Dr. Lemuel W. Diggs, Director of the Department of Medical Laboratories for the University of Tennessee and City of Memphis Hospitals.

Highlights of the Eighty-Third Annual Meeting

(1) A portion of the 2,108 persons registers for the Annual Meeting. (2) Dr. Lemuel W. Diggs, of Memphis, the President's guest speaker, delivers his address on "Management of Hemorrhagic Diseases." (3) The Conference of County Medical Society Presidents and Secretaries planned by Dr. William C. Roberts, President-Elect, is held at breakfast in the main dining room of the Hollywood Beach Hotel. (4) The Pageant Room is filled for the closed circuit television program moderated by Dr. Robert J. Needles, of St. Petersburg, and sponsored by Smith, Kline & French Laboratories. (5) The Patio Party is held in the Southwest Gardens of the Hollywood Beach Hotel. (6) President-Elect Roberts is escorted to the rostrum for the installation ceremonies by Dr. Herbert L. Bryans, of Pensacola, and Dr. David R. Murphey Jr., of Tampa. (7) The engraved gavel is presented by retiring president, Dr. Francis H. Langley, to Dr. Roberts. (8) A group of physicians who have been members of the Association for 35 years or more assemble following presentation of certificates by Dr. Samuel M. Day, Secretary-Treasurer. (9) Dr. Jere W. Annis, of Lakeland, is escorted to the rostrum by Drs. Marion W. Hester and Charles Larsen Jr., also of Lakeland, following his election as President-Elect.

"Dr. Diggs is a Virginian by birth and a Tennessean by adoption, having been a Memphian for a quarter of a century. Born in Hampton, Va., in 1900, Dr. Diggs spent his early years in his native state and also received his academic training there. He was awarded the degrees of Bachelor of Science and Master of Arts by Randolph Macon College. For his medical training he chose the Johns Hopkins University School of Medicine, where he received the degree of Doctor of Medicine in 1926.

"After spending three years in postgraduate work in medicine at the University of Rochester's Strong Memorial Hospital in Rochester, N. Y., Dr. Diggs joined the staff of the University of Tennessee College of Medicine as a pathologist. Later he transferred to the Division of Medicine as a Professor of Medicine and Director of the Department of Medical Laboratories for the University of Tennessee and city of Memphis Hospitals. For two years he was the clinical pathologist for the Cleveland Clinic Foundation in Cleveland, Ohio. He is now a consultant to the Tennessee Valley Authority and to the Armed Forces Institute of Pathology in Washington, D. C.

"Locally, Dr. Diggs takes an interest in community activities. His principal hobby is farming.

"A member and a former vice president of the American Society of Clinical Pathologists, he is also a member of the College of American Pathologists and the International Society of Hematology. At present, he is chairman of the Council on Hematology of the American Society of Clinical Pathologists. He also holds membership in the American Medical Association and the Southern Medical Association.

"The principal research in which Dr. Diggs has engaged has been in the fields of clinical pathology and hematology. He has written many articles on sickle cell anemia, his chief interest. He is the author of a new text entitled 'Morphology of Human Blood Cells.' His laboratory manual, bearing the title 'Laboratory Procedures Used at the John Gaston Hospital,' is widely used throughout the South. For the last three editions of Miller's 'Textbook of Clinical Pathology' he has served as the co-author. In addition, he has contributed to 'Current Therapy' and 'Gould's Medical Dictionary.'

"Dr. Diggs will speak on 'Management of Hemorrhagic Diseases.'"

(Dr. Diggs' address will appear in the August issue.)

After a short recess to visit exhibits, the general session was continued with Dr. George T. Harrell Jr., Chairman, Scientific Work Committee, presiding.

Dr. Harrell: "It is a pleasure to bring to you Dr. J. R. Heller, Director, National Cancer Institute, Bethesda, Maryland. Dr. Heller was born in South Carolina and received his M.D. degree from Emory University in 1929. He was with the U. S. Public Health Service for many years, is on the faculty of George Washington University, and was made Director of the National Cancer Institute in 1948."

Dr. Heller spoke on "Progress in Cancer Control," which will appear in a subsequent issue of The Journal.

Dr. Harrell: "Our next speaker is Dr. Thomas Findley, Research Professor of Medicine for Cardiovascular Diseases, Medical College of Georgia, Augusta.

"Dr. Findley received his M.D. degree from Rush Medical College in 1928. He has been Instructor in Internal Medicine at Michigan University, Chief of the Medical Section of Ochsner Clinic, Professor of Clinical Medicine at Tulane, and came to the University of Georgia in 1954 as Research Professor of Medicine for Cardiovascular Diseases."

Dr. Findley spoke on "Diuresis and Antidiuresis," which will appear in a subsequent issue of the Journal.

The general session was adjourned at 12:30 p.m.

FIRST HOUSE OF DELEGATES

The House of Delegates convened at 2:30 p.m., Sunday, May 5, 1957, in the Pageant Room of the Hollywood Beach Hotel, Hollywood, Florida, with Dr. Francis H. Langley, President, in the Chair.

Dr. Langley: "During past years, there has been some confusion as to the function of the Chair and the Parliamentarian. The sole function of the Parliamentarian is to advise me on moot points of parliamentary procedure when I consider it necessary. This I shall do privately. The Chair is under no obligation to accept his decision. Ultimate decisions will be made by me. All remarks and parliamentary inquiries will be addressed to the Chair, and not to the Parliamentarian.

"Dr. George F. Schmitt Jr., who is a registered parliamentarian, will be glad to consult with any member of the House of Delegates concerning parliamentary matters. This, however, must not be done during the formal sessions. In an effort to aid the delegates, some literature has been distributed."

Dr. Louis M. Orr, Chairman of the Credentials Committee, announced that a quorum was present, 112 delegates being registered. (Subsequent report of the Credentials Committee showed that 154 delegates were registered.)

Dr. David R. Murphey Jr., of Hillsborough, moved that the delegates be seated.

Seconded by Dr. Herbert L. Bryans.

Motion carried.

Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, Walter E. Murphree
BAY—Harold E. Wager
BREVARD—Thomas C. Kenaston, Arthur C. Tedford
BROWARD—Norris M. Beasley, Julius F. Boettner, Burns A. Dobbins Jr., Anthony C. Galluccio, John H. Mickley, Richard A. Mills, Paul G. Shell
COLLIER—Daniel B. Langley
COLUMBIA—Louis G. Landrum
DADE—James L. Anderson, Edward R. Annis, Morris H. Blau, Reuben B. Chrisman Jr., Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, M. Jay Flipse, Milton S. Goldman, Maurice M. Greenfield, W. Tracy Haverfield, James W. Holmes, R. Spencer Howell, Ralph W. Jack, Joseph T. Jana Jr., Walter C. Jones, David Kirsh, Alfred G. Levin, Donald F. Marion, John D. Milton, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett Jr., T. D. Sandberg, Ralph S. Sappenfield, George F. Schmitt Jr., Donald W. Smith, Joseph S. Stewart, William M. Straight, Oliver P. Winslow Jr., Jack L. Wright, Corren P. Youmans, Nelson Zivitz
DeSOTO-HARDEE-HIGHLANDS-GLADES — Carl J. Larsen
DUVAL—Frederick H. Bowen, Hugh A. Carithers, Turner Z. Cason, Frank L. Fort, A. Judson Graves, Karl B. Hanson, Gordon H. Ira, Edward Jelks, Raymond H. King, Joseph J. Lowenthal, Charles F. McCrory, Richard G. Skinner Jr., John T. Stage, Sidney Stillman, Leo M. Wachtel, Ashbel C. Williams
ESCAMBIA—Paul F. Baranco, Herbert L. Bryans, Joseph W. Douglas, Alpheus T. Kennedy *(Absent—Walter C. Payne Sr.)*
FRANKLIN-GULF—John W. Hendrix
HILLSBOROUGH—Samuel H. Adams, Efrain C. Azmitia, Leffie M. Carlton Jr., C. Frank Chunn, Herschel G. Cole, H. Phillip Hampton, David R. Murphey Jr., James N. Patterson, Madison R. Pope, William M. Rowlett, Wesley W. Wilson
INDIAN RIVER—William L. Fitts 3rd
JACKSON-CALHOUN—James T. Cook Jr.
LAKE—George E. Engelhard
LEE-CHARLOTTE-HENDRY—William H. Grace, John S. Stewart
LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—Francis T. Holland, George H. Massey, Robert H. Mickler
MADISON—Wilmer J. Coggins
MANATEE—Richard V. Meaney
MARION—Henry L. Harrell, Eugene G. Peek Jr.
MONROE—Ralph Herz
NASSAU—*(Absent—Benjamin F. Dickens)*
ORANGE—Frank C. Bone, Chas. J. Collins, Norman F. Coulter, Harry H. Ferran, Walter B. Johnston, Fred Mathers, Louis M. Orr, Charles R. Sias, W. Dean Steward, Robert L. Tolle
PALM BEACH—Willard F. Ande, Edwin W. Brown, V. Marklin Johnson, Walter R. Newbern, Raymond S. Roy, W. Lawson Shackelford, A. Scott Turk, Edward W. Wood
PASCO-HERNANDO-CITRUS—S. Carnes Harvard
PINELLAS—Clyde O. Anderson, M. Eldridge Black, Harry R. Cushman, William D. Futch, N. Worth Gable, Percy H. Guinand, Norval M. Marr Sr., Joseph W. Pilkington, George H. Schoetker, James E. Thompson, Walter H. Winchester, Rowland E. Wood
POLK—Jere W. Annis, James R. Boulware Jr., Samuel J. Clark, Marion W. Hester, Charles Larsen Jr.
PUTNAM—*(Absent—Lawrence G. Hebel)*
ST. JOHNS—Herbert E. White
ST. LUCIE-OKEECHOBEE-MARTIN — Richard F. Sinnott
SARASOTA—John M. Butcher, Melvin M. Simmons *(Absent—Hugh G. Reaves)*
SEMINOLE—Daniel H. Mathers
SUWANNEE—Edward G. Haskell Jr.
TAYLOR—John H. Parker Jr.
VOLUSIA—C. Robert DeArmas, William R. Hutchinson, Alphonsus M. McCarthy, Arthur Schwartz
WALTON-OKALOOSA—Frederic E. Caldwell
WASHINGTON-HOLMES—Walter H. Shehee
STATE OFFICERS—Francis H. Langley, William C. Roberts, Meredith Mallory, Kenneth A. Morris, Cecil M. Peek, Samuel M. Day, Shaler Richardson

Dr. Langley declared the Eighty-Third Annual Session duly opened.

On motion by Dr. Ralph Herz, seconded by Dr. Walter C. Jones, and carried, the proceedings of the Eighty-Second Annual Meeting as published in the July 1956 Journal were approved.

On motion by Dr. Shaler Richardson, seconded by Dr. S. Carnes Harvard, and carried, the proceedings of the Called Meeting of November 4,

1956 as published in the February 1957 Journal were approved.

President Langley relinquished the Chair to Dr. Meredith Mallory, First Vice President.

Dr. Mallory: "Since the election of a year ago this is the first opportunity that a Vice President has had to function. It is probably only right that I make proper use of it whether or not it proves a burden to you. How well do I know that you did not come here to see me or to hear me, but I have you at a distinct disadvantage. According to the program this is my time and the parade cannot go on until I have finished. However, I do not intend to usurp the time and I know you will be surprised to learn whom I am supposed to introduce, and furthermore, you may or may not have even heard of him.

"Our next speaker comes from the Buckeye State, having been born in Cumberland, Ohio, on the 23rd of October, 1899 and he arrived in Florida in October 1909. He graduated at Ohio Wesleyan with a B. A. degree and in the year 1926 received his Doctor of Medicine from Johns Hopkins. His immediate hospital training was at the Hospital for Women in Maryland where he was an intern, assistant resident and resident, finishing in 1929. He also holds a Honorary Doctor of Science from Ohio Wesleyan University received in 1956.

"He is a Fellow of the American College of Surgeons, Fellow of Southeastern Surgical Congress, Member of Florida Council of American College of Surgeons and former Chairman of First Congressional District, Florida Medical Committee for Better Government.

"He has served the Florida Medical Association well, having been First Vice President in 1952, member of the Board of Governors 1950-55, and Chairman of the Council in 1954.

"He belongs to the Lions Club, the American Legion, St. Peterbsurg Chamber of Commerce, the St. Petersburg Yacht Club and Sunset Country Club. He is a 32nd degree Mason and a Shriner belonging to Egypt Temple.

"His army service followed closely his activities in civilian life. He was Chief of Surgery of an evacuation hospital in E.T.O., was decorated with five Battle Stars, the Bronze Star and the Victory Medal. He was Chief of Surgery at Station Hospital at Camp Croft, and held the rank of Lt. Colonel.

"His church affiliation is the Methodist Church and he has been a trustee of Christ Methodist Church since 1931.

"His fraternities are Phi Delta Theta, Phi Beta Kappa, and Alpha Kappa Kappa.

"On October 26, 1929 he married Miss Sarah Graham Hall of Charlotte, N. C. and they have four children, Ann Carter, James Nelson, Peter and Elizabeth Hall.

"He is Chief of Surgery at Mound Park Hospital and former Chief of Staff of St. Anthony Hospital.

"It has been my opportunity to have been associated with him on various committees and I can assure you that the Florida Medical Association has been fortunate to have had his advice and counsel during the past few years.

"It is indeed not only a privilege but also a pleasure to present to you your President—Dr. Francis H. Langley, of St. Petersburg."

Dr. Langley delivered his presidential address. (The complete text may be found in this issue of The Journal on page 19.)

Dr. Mallory: "Mr. President, we all enjoyed your talk very much. I want to congratulate you on your accomplishments, and it is with a great deal of pleasure that I return the gavel to you."

Dr. Langley: "It is my honor and privilege to recognize a distinguished visitor from another profession which we all respect and to which we owe very much. I refer to Mr. Baya M. Harrison Jr., of St. Petersburg, who last night assumed office as President of The Florida Bar. He has been a member of the Board of Governors of that organization since 1952. He graduated in law from the University of Florida in 1935. During World War II, he served for four years and ended as a Colonel in the Artillery. He and his wife are with us and it is my pleasure to invite Mr. Harrison to the rostrum."

Mr. Harrison: "President Langley, Dr. Mallory, Members of the House of Delegates of the Florida Medical Association, Ladies and Gentlemen:

"I am privileged on behalf of the 7,000 lawyers and judges of Florida to extend the warm and cordial greetings of The Florida Bar.

"I am also personally grateful for the opportunity to be present because as a lawyer and as a citizen I have an abiding regard for the medical profession and for those of your members who address to their important task the full measure of their learning and sympathy.

"To those of you who are not fully aware of the organized bar of Florida, it has imposed upon it by a ruling of the Supreme Court of this state, the important responsibility of assuring the

competence and integrity of the Bar and the public service of its members. It is not a voluntary group and all practicing lawyers and judges which the provisions of the law require to be lawyers are members. Overriding those responsibilities is the larger one, which has been our responsibility since the world began, and that is to improve the administration of justice. It is in that important respect that the Florida Bar has welcomed the cooperative efforts of the Florida Medical Association in assisting in the administration of justice. In the past 15 or 20 years it became more apparent that doctors are so important to the proper administration of justice that we of the Florida Bar are very glad that there has come about a Guide for Cooperation Between Lawyers and Doctors of Florida, with the idea of improving the administration of justice. We are aware of the important part the doctor has in cases in which you appear as witnesses before the court.

"It is a great pleasure to be here and I thank you for including my wife in your invitation."

Dr. Langley: "Thank you very much, Mr. Harrison."

"It is now my pleasure to recognize the members of the Woman's Auxiliary."

Mrs. Perry D. Melvin: "As President-elect, I am here to represent the Auxiliary. Our President and our distinguished guests are in our Board meeting."

Dr. Langley: "Early this year the Dade County Medical Association, the Miami Herald, the Dade County Health Department and the Dade County Chapter of the National Foundation for Infantile Paralysis sponsored a very successful poliomyelitis immunization drive. The major part of this drive preceded the current campaign, ending June 30, in which the Florida Medical Association, through its component county medical societies, is encouraging the increased use of poliomyelitis vaccine in all age groups. During the nine-week drive over 247,000 cc. of vaccine were distributed in the Miami area, of which some 70% was administered by private physicians. This is a considerably larger amount of vaccine than the total amount distributed in Dade County during the entire time prior to the drive.

"Although all of the news media in the area provided excellent support during the campaign, one of the primary factors contributing to the tremendous success of the drive was the human interest news reporting done by Mr. Lawrence R. Thompson, of the Miami Herald.

"In recognition of Mr. Thompson and the Miami Herald for this outstanding journalistic effort on behalf of public health, the Florida Medical Association is privileged to present an official citation. If Mr. Thompson is present, will he please come forward to receive the citation at this time?"

Mr. Thompson came to the rostrum.

Dr. Langley: "I should like to read the citation: 'The Florida Medical Association is privileged to present this citation to Lawrence R. Thompson, of the Miami Herald, in recognition of exemplary and unselfish service in the interest of public health during the poliomyelitis immunization drive, January-March, 1957, Miami, Florida. Presented, May 1957.'"

The Chair recognized Dr. Louis M. Orr, Chairman of the Credentials Committee.

Dr. Orr: "I am very pleased to announce, on behalf of the Credentials Committee, that 154 delegates and officers out of a total of 158 are now seated."

Dr. Langley introduced Dr. Homer L. Pearson Jr., Secretary, State Board of Medical Examiners, who gave his annual report, which was referred to Reference Committee No. 1.

Dr. Langley: "We are very fortunate to have with us Lt. Col. E. G. Rivas, MSC, Director, Inquiries and Liaison, Office for Dependents' Medical Care, Washington, D. C."

(Col. Rivas' address appears in this issue on page 27.)

Dr. John D. Milton reported briefly on the progress of the Medicare program.

Dr. Donald F. Marion, General Chairman of the Medicare Fee Schedule Committee, presented a report, which was referred to Reference Committee No. 3.

President Langley called for the election of one delegate and one alternate to the House of Delegates of the American Medical Association, for two-year terms beginning January 1, 1958.

The Chair recognized Dr. W. Tracy Haverfield, of Dade.

Dr. Haverfield: "President Langley, Members of the House of Delegates: I have the honor and privilege to place in nomination as your delegate to the American Medical Association, the name of a man to succeed himself, a man who has served you vigorously and well for a number of years in that capacity, a man who is at present Vice Speaker of the House of Delegates of the A.M.A., a man who, if every indication is correct,

will probably become President-Elect of the A.M.A. in 1958, thereby bringing honor not only to himself but to the State of Florida. Gentlemen, I give you Dr. Louis Orr, of Orlando."

Dr. Robert L. Tolle: "It is my personal pleasure and I have been instructed to second this nomination in behalf of the Orange County delegation."

Dr. Ralph Herz: "I move that the nominations be closed and the secretary be instructed to cast a unanimous ballot for Dr. Orr."

Seconded by Dr. H. Phillip Hampton.

Motion carried.

Dr. David R. Murphey Jr.: "As our alternate delegate, I wish to nominate Dr. Richard A. Mills."

Dr. John D. Milton moved that nominations be closed.

Seconded by Dr. Walter W. Sackett Jr.

Motion carried.

Dr. Langley read the personnel of the four reference committees as follows:

1. HEALTH AND EDUCATION
 - Leo M. Wachtel, Chairman
 - C. Frank Chunn
 - V. Marklin Johnson
 - Charles R. Sias
 - Paul F. Baranco
2. PUBLIC POLICY
 - Chas. J. Collins, Chairman
 - S. Carnes Harvard
 - Burns A. Dobbins Jr.
 - James T. Cook Jr.
 - Leffie M. Carlton Jr.
3. FINANCE AND ADMINISTRATION
 - Norval M. Marr Sr., Chairman
 - Donald W. Smith
 - Sidney Stillman
 - James R. Boulware Jr.
 - Francis T. Holland
4. LEGISLATION AND MISCELLANEOUS
 - L. Washington Dowlen, Chairman
 - Raymond H. King
 - Melvin M. Simmons
 - Alpheus T. Kennedy
 - Jack Q. Cleveland

The following committee reports and resolutions were referred as published in the Handbook, together with supplemental reports and additional resolutions as presented:

(To Reference Committee No. 1)

Scientific Work, George T. Harrell Jr.
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Ashbel C. Williams
Venereal Disease Control, C. W. Shackelford
Tuberculosis and Public Health, Phillip W. Horn
Maternal Welfare, E. Frank McCall
Child Health, Warren W. Quillian
State Board of Medical Examiners, Homer L. Pearson Jr., Secretary

(To Reference Committee No. 2)

Conservation of Vision, Charles C. Grace
*Medical Education and Hospitals, Walter E. Murphree
Medical Economics, Robert E. Zellner
Representatives to Industrial Council, Chas. L. Farrington
Grievance, David R. Murphey Jr.
Nursing, Jere W. Annis
Blood, Louis E. Pohlman
*Supplemental report presented and referred.

(To Reference Committee No. 3)

Address of President, Francis H. Langley
*Board of Governors, Francis H. Langley
*Necrology, Alvin L. Stebbins
Advisory to Woman's Auxiliary, John P. Ferrell
*Councilor Districts and Council, Herschel G. Cole
*Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, Rowland E. Wood
Blue Shield Liaison, Henry J. Babers Jr.
Resolution: Blue Shield Service Category, Hillsborough County Medical Association
Resolution: Blue Shield Fee Schedule, Escambia County Medical Society
Reports: Medicare Program, John D. Milton
Medicare Fee Schedule, Donald F. Marion
*Supplemental reports presented and referred.

(To Reference Committee No. 4)

*Legislation and Public Policy, H. Phillip Hampton
Mental Health, Sullivan G. Bedell
State Controlled Medical Institutions, William D. Rogers
Poliomyelitis Medical Advisory, Richard G. Skinner Jr.
Resolution: Changes in State Welfare Law, Escambia County Medical Society
Resolution: Workmen's Compensation Fee Schedule, Escambia County Medical Society
*Supplemental report presented and referred.

The Chair called for resolutions from the floor.

Dr. Herbert L. Bryans, of the Escambia County Medical Society presented three resolutions as follows: a resolution on replacement of blood by Medicare patients which was referred to Committee No. 3; a resolution on the Annual Dinner, referred to Committee No. 4, and a resolution on non-cancellable health and accident insurance policies, referred to Committee No. 2.

Dr. Frank C. Bone, of the Orange County Medical Society, presented a resolution on indigent service, which was referred to Committee No. 4.

Dr. Walter E. Murphree, Chairman, Medical Schools Liaison Committee, presented the report of this special committee, which was referred to Committee No. 2.

Dr. Walter H. Winchester, of the Pinellas County Medical Society, presented a resolution on minimum standards for motor vehicle licensing, which was referred to Committee No. 4.

Dr. Burns A. Dobbins Jr., of the Broward County Medical Association, presented two resolutions: a resolution on increased Blue Cross-Blue Shield benefits, and a resolution on Medicare. Both of these were referred to Committee No. 3.

Dr. Samuel M. Day, Secretary-Treasurer, read a letter from the Orange County Medical Society, regarding a bill S. 727 on scholarships for children of veterans, which was referred to Committee No. 4.

The Secretary also read a resolution from the Orange County Medical Society on Abolition of Tuberculosis Board, which was referred to Committee No. 4.

As Dr. Alvin L. Stebbins, Chairman of the Committee on Necrology, was not present, Dr. Day read the supplemental report of the Committee on Necrology. Two names were added from the floor, Dr. Ralph S. Torbett, of Tampa, and Dr. Gordon F. Henry, of West Palm Beach.

Dr. Langley recognized Dr. Edward Jelks, President, Florida Medical Foundation.

Dr. Jelks: "I wish to present to you the finest opportunity the doctors of this state have ever had to accomplish a great deal for our Association and to provide better medical care for the people of Florida.

"In his address, our President has given you the history of the Foundation. The next thing, is money. I am here to ask you to participate in this Foundation, which is your Foundation. This morning at breakfast, one doctor said, 'I will give you $100 if you will send $25 to my medical school.' You can earmark the money to go anywhere for any purpose that is covered by our charter. If you will read this charter, you will find that the Foundation can send your contribution to almost any good cause in the United States.

"We are anxious to get as many doctors' names as possible on our list of contributors because this will encourage others to give to the Foundation. In this way, we hope to get sizeable contributions. This is not our idea—it is the idea of people who handle trusts—and they have passed it on to us. They told us that we will not be able to interest others until the doctors themselves contribute.

"Let's take this seriously. We will send your contributions wherever you want them to go. If you have any questions, Dr. Milton, Dr. Anderson, Mr. Parham or I will give you more information while you are here. This gives us a wonderful opportunity to render a great service."

Several of the members rose and stated their intentions to contribute.

Dr. Langley announced that an emergency hospital unit had been erected outside the hotel by Civil Defense, and that all doctors were invited to inspect it.

Dr. Walter C. Jones announced that the Southern Medical Association was planning a headquarters building and would welcome contributions from the doctors.

There being no further business, the House of Delegates recessed at 5:10 p.m. to reconvene at 9:30 a.m. on Wednesday, May 8, 1957.

SECOND HOUSE OF DELEGATES

The House of Delegates reconvened at 9:30 a.m. on Wednesday, May 8, 1957, in the Pageant Room of the Hollywood Beach Hotel, Hollywood, President Francis H. Langley in the Chair.

Dr. Louis M. Orr, Chairman of the Credentials Committee, was recognized and reported that a quorum was present. (Subsequent report of the Credentials Committee showed 146 delegates registered.)

Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, Walter E. Murphree
BAY—*(Absent—Harold E. Wager)*
BREVARD—Thomas C. Kenaston, Arthur C. Tedford
BROWARD—Norris M. Beasley, Julius F. Boettner, Burns A. Dobbins Jr., Anthony C. Galluccio, John H. Mickley, Richard A. Mills, Paul G. Shell
COLLIER—Daniel B. Langley
COLUMBIA—Louis G. Landrum
DADE—James L. Anderson, Edward R. Annis, Morris H. Blau, Reuben B. Chrisman Jr., Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, M. Jay Flipse, Milton S. Goldman, Maurice M. Greenfield, W. Tracy Haverfield, James W. Holmes, R. Spencer Howell, Ralph W. Jack, Joseph T. Jana Jr., Walter C. Jones, Alfred G. Levin, Donald F. Marion, John D. Milton, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett Jr., T. D. Sandberg, Ralph S. Sappenfield, George F. Schmitt Jr., Donald W. Smith, Joseph S. Stewart, William M. Straight, Jack L. Wright, Corren P. Youmans *(Absent—David Kirsh, Oliver P. Winslow Jr., Nelson Zivitz)*
DeSOTO-HARDEE-HIGHLANDS-GLADES — *(Absent—Carl J. Larsen)*
DUVAL—Frederick H. Bowen, Hugh A. Carithers, Turner Z. Cason, Frank L. Fort, A. Judson Graves, Karl B. Hanson, Gordon H. Ira, Edward Jelks, Raymond H. King, Joseph J. Lowenthal, Charles F. McCrory, Richard G. Skinner Jr., Sidney Stillman, Leo M. Wachtel, Ashbel C. Williams *(Absent—John T. Stage)*

ESCAMBIA—Paul F. Baranco, Herbert L. Bryans, Joseph W. Douglas, Alpheus T. Kennedy, Clyde E. Miller Jr.
FRANKLIN-GULF—John W. Hendrix
HILLSBOROUGH—Samuel H. Adams, Efrain C. Azmitia, Leffie M. Carlton Jr., Herschel G. Cole, H. Phillip Hampton, David R. Murphey Jr., James N. Patterson, Madison R. Pope, William M. Rowlett, Wesley W. Wilson *(Absent—C. Frank Chunn)*
INDIAN RIVER—William L. Fitts 3rd
JACKSON-CALHOUN—James T. Cook Jr.
LAKE—George E. Engelhard
LEE-CHARLOTTE-HENDRY—William H. Grace, John S. Stewart
LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—Francis T. Holland, George H. Massey, Robert H. Mickler
MADISON—*(Absent—Wilmer J. Coggins)*
MANATEE—Richard V. Meaney
MARION—Henry L. Harrell, Eugene G. Peek Jr.
MONROE—*(Absent—Ralph Herz)*
NASSAU—Cecil B. Brewton
ORANGE—Frank C. Bone, Chas. J. Collins, Norman F. Coulter, Harry H. Ferran, Walter B. Johnston, Fred Mathers, Louis M. Orr, Charles R. Sias, W. Dean Steward, Robert L. Tolle
PALM BEACH—Willard F. Ande, Edwin W. Brown, V. Marklin Johnson, Walter R. Newbern, Raymond S. Roy, W. Lawson Shackelford, A. Scott Turk, Edward W. Wood
PASCO-HERNANDO-CITRUS—S. Carnes Harvard
PINELLAS—Clyde O. Anderson, M. Eldridge Black, Harry R. Cushman, William D. Futch, Percy H. Guinand, Norval M. Marr Sr., Joseph W. Pilkington, George H. Schoetker, James E. Thompson, Walter H. Winchester, Rowland E. Wood *(Absent—N. Worth Gable)*
POLK—Jere W. Annis, James R. Boulware Jr., Samuel J. Clark, Marion W. Hester, Charles Larsen Jr.
PUTNAM—*(Absent—Lawrence G. Hebel)*
ST. JOHNS—Herbert E. White
ST. LUCIE-OKEECHOBEE-MARTIN — Richard F. Sinnott
SARASOTA—John M. Butcher, Melvin M. Simmons *(Absent—Hugh G. Reaves)*
SEMINOLE—Daniel H. Mathers
SUWANNEE—Edward G. Haskell Jr.
TAYLOR—John H. Parker Jr.
VOLUSIA—C. Robert DeArmas, William R. Hutchinson, Alphonsus M. McCarthy, Arthur Schwartz
WALTON-OKALOOSA—Frederic E. Caldwell
WASHINGTON-HOLMES—Walter H. Shehee
STATE OFFICERS—Francis H. Langley, William C. Roberts, Meredith Mallory, Kenneth A. Morris, Cecil M. Peek, Samuel M. Day, Shaler Richardson

Dr. Langley: "I have taken the liberty of changing the order of business slightly this morning and instead of following the program exactly, we will now hear from the representative of the University of Florida to the Student American Medical Association Convention. I would like to introduce two medical students from the University of Florida, Mr. Marvin I. Baker and Mr. Bill R. Blakey."

"Mr. Baker will give us the report on the Student A.M.A. Convention."

Report on National Convention of the Student American Medical Association

It is the purpose of this report to acquaint the members of the Florida Medical Association with the aims and ideals of the Student American Medical Association, as well as to inform them of the proceedings of the national convention held in Philadelphia on May 3, 4, and 5. It is hoped that the first expressed purpose will be accomplished through the summary of the convention proceedings. Because of the large number of items considered at the convention, it is necessary to restrict this report to those items which are judged to be of more direct interest to the members of the Florida Medical Association.

Several items concerning medical education were considered and acted upon. For several years, Student American Medical Association chapters have been sending internship evaluation forms to their recent graduates for the purpose of establishing files on as many hospitals as possible. The returned questionnaires enable currently enrolled students considering internships to learn of the educational opportunities and economic aid provided by a given hospital. Legislation to provide for a central file on each hospital to contain percentage tabulations of answers to each question of a standard evaluation form was enacted. Funds are not available for this operation as yet; but since such a file would be of considerable value to the prospective intern, it is expected that this difficulty will be overcome in the near future.

The economic plight of most married interns is well known in medical circles. The Student American Medical Association conducted a survey of medical students and found that 54 per cent of students entering their senior year are married and that 46 per cent of students entering their junior year are married. It was further determined that at the time that maintenance — room, board, laundry, and stipend — was instituted for the intern, the married intern was somewhat of a rarity. Provision for the economic maintenance of the married intern and his family is far from adequate. The national organization is now undertaking a survey for the purpose of publishing a comparison of the index of the cost of living with the index of economic maintenance by hospitals. Since cost of living indices vary widely over the nation, this information will be by geographic area. The statistics provided by the survey will be made available to all hospitals; and since it is generally those hospitals which offer the finest educational opportunities that have the smallest provision for the economic welfare of the intern, it will be pointed out that when more graduates can afford these internships, the increased number of applicants will very likely provide these hospitals with a better class of interns.

The increasing occurrence of malpractice suits brought against interns and residents was pointed out at a preconvention meeting of the advisory committee of the local chapter with the chapter officers. At the national convention, a resolution stating the problem and designed to institute a survey to determine the extent of such suits and the best possible method of resolving the situation was introduced and passed. It is understood that to an intern or resident, the cost of malpractice insurance is prohibitive.

As many physicians realize, there is a great need among many medical students for financial aid. The ideal way to meet and continue meeting this need would be to establish a loan fund which would operate on a no interest, postgraduate payment plan. Under this plan, loans should be available to any student judged to be likely to complete his academic work and deemed to be in need of financial aid. Such a plan, in freeing the needy student of a heavy financial burden, would permit him to function more efficiently in school and would serve to encourage application to medical school by those who are interested in medicine as a career but choose another field because of the financial difficulties involved in medical training.

The Student American Medical Association for several years has attempted to institute a loan plan similar to the one outlined above. Donations have been solicited from various professional organizations and individuals, but the amount received is not yet sufficient to begin operation of the plan. However, a Board of Trustees has been established for the administration of the funds.

The author of this report has no information concerning the amount of money needed on a national scale, but feels capable of making an estimate of the local need. Approximately one third of the members of the freshman class of the University of Florida College of Medicine, or 15 students, are in need of financial aid. A reasonable estimate would be $500 for each of four years, or a total of $2,000 per student. Since full-scale operation of the school must be considered, the need, with four classes, will be $30,000 per year, or $180,000 for the first six year period. Since repayment of loans will be extensive by the end of six years, the amount needed each year after that would progressively diminish. It might be added that the full amount received as donations to this fund would be paid out as loans, since the College of Medicine will provide for administration of the funds at its own expense.

Curriculum evaluation programs are being conducted by individual chapters, and recommendations are made by the national organization for improvement of education standards and methods in medical schools. These recommendations are published in the monthly journal of the Student American Medical Association, now known as *New Physician*.

The national organization urged its individual chapters to continue to improve their premedical student counseling programs. These are designed to improve the quality of applicants to medical schools by stimulating interest among the more superior students.

There is also a survey of high school students to determine their scientific interests. It is hoped that this survey will indicate better ways to stimulate interest in medicine as a career among scientifically inclined students and provide educators with more knowledge of deficiencies in scientific education in the public schools.

Several constitutional amendments designed to expand the range of the Student American Medical Association and to provide membership in a medical organization for those who are in postgraduate training were approved. Now a medical student can have membership through medical school, internship, and residency by payment of the $4 membership fee in his freshman year. This fee is paid only once and covers membership (including the monthly publication) for the duration of this training.

Another amendment involves the creation of geographical regions, each to elect its own regional vice president. The purpose of this arrangement is to facilitate exchange of ideas among chapters; and since each regional vice president is a member of the executive council, individual chapters will more closely determine national policy.

As sidelights to the convention, there were some very interesting programs, such as presentations of scientific papers by students, a panel discussion by nationally prominent physicians concerning specialty and general practice, and technical exhibits by drug and equipment companies.

The Florida Student Medical Association has received valuable aid and guidance from Dr. Carl Herbert, representing the Florida Medical Association, and Dr. Thomas Brill, representing the Alachua County Medical Society, and would like to express its appreciation to them and to their respective societies for providing these representatives to the advisory committee of the Florida Student Medical Association.

The author of this report, representing the Florida Student Medical Association chapter at the University of Florida College of Medicine, feels that the Student American Medical Association is a living organization which is taking great strides toward fulfillment of its purpose to help improve medical standards over the nation and to better educational opportunities. The Florida Student Medical Association stands to gain much from its membership in the Student American Medical Association and would like to express its appreciation to the Florida Medical Association for providing it with the opportunity to be represented at the national convention and for permitting this report to be presented before the House of Delegates of the Florida Medical Association.

Respectfully submitted,
Marvin I. Baker, *Delegate*

Dr. Langley: "We now go to something that is different. We have arranged to present certificates to our Life Members. To those that are not in attendance, the certificate will be mailed later. In subsequent years, it is intended that Life Members will receive their certificates each year at the convention. I now turn this pleasant duty over to our Secretary, Dr. Sam Day."

Dr. Day: "It has been said that the feeling of having done a job well is rewarding; the feeling of having done it perfectly is fatal. Certainly, we men of medicine are not too often bothered with the feeling of having done it perfectly, but it is rewarding to have done the job well. Our Life Members deserve some distinction. They have done the job well and we want to show our appreciation for it. For the first time, we have prepared a certificate. As Dr. Langley mentioned in his address, the first one was awarded to Dr. Joseph Halton of Sarasota on his fiftieth anniversary. We are now going to present certificates to those who have been in the Association for 35 years and hereafter they will be presented each year at the Convention."

Dr. Day called the roll of Life Members and presented certificates to those in attendance.

Dr. Langley: "We will now take up the recommendations of the Reference Committees. We will hear first from Dr. Leo M. Wachtel, Chairman, Committee No. 1, Health and Education."

Report of Reference Committee No. 1

Dr. Wachtel: "Mr. President and Members of the House of Delegates:

"Your reference committee gave careful consideration to items referred to it and makes the following report:

"The Report of the Committee on Scientific work, Dr. George T. Harrell Jr., Chairman, is approved as printed in the Handbook.

"I move the adoption of this portion of the report."

Seconded by Dr. James N. Patterson.

Motion carried.

Report of Committee on Scientific Work

George T. Harrell Jr., *Chairman*

In an effort better to organize the work of the Association during the Annual Meeting, the Committee on Scientific Work planned a different program than in recent years. The scientific papers have been grouped in two sessions in a single day so that the House of Delegates and Reference Committees might meet without conflict with other activities. A new feature of the program has

been the inclusion of a closed-circuit television program in conjunction with other state societies meeting concurrently.

The scientific exhibit has been increased in variety. It is recommended that more flexibility in size of space for individual exhibits be provided in the future if possible. An expanded program of scientific movies has been arranged along with kinescopes of nationally televised medical programs. This feature might warrant further emphasis in future years.

The Committee met on December 1, 1956 in Gainesville to select the papers, exhibits, movies, moderators of the panels, and the other details of the selection of the program. The number of applications for a place on the program was gratifying, but the lateness of many inquiries made the work of the Committee unduly heavy. Greater emphasis should be placed on early submission of titles and abstracts so that the complete program can be selected by the middle of January and printed in The Journal on time. If the number of titles submitted continues to increase, the Committee might be enlarged and divided into separate sub-committees which could be responsible for the selection of scientific exhibits, movies, papers, and discussants.

The Committee recommends the continuation of the appropriation of $250 per year, first granted in 1954, to permit the invitation of out-of-state distinguished guests for participation on panels, symposia, and the general session program.

"The Report of the Committee on Medical Postgraduate Course, by Dr. Turner Z. Cason, Chairman, is approved as printed in the Handbook.

"The reference committee took note of the unselfish and untiring work of the chairman, Dr. Turner Z. Cason, who is retiring from this position after 26 years of service to the physicians of Florida.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. W. Dean Steward.

Motion carried.

Report of Committee on Medical Postgraduate Course

Turner Z. Cason, *Chairman*

The only meeting of the Medical Postgraduate Course Committee during the year 1956 was held at 10:30 A.M. Sunday, October 28, at the Medical Science Building, College of Medicine, University of Florida, in Gainesville.

The appointment of Dr. William C. Thomas Jr., of Gainesville as Director of the Division of Postgraduate Education, College of Medicine, University of Florida, was made at the time of his introduction to the group. Dr. Thomas will assume the duties of this office on July 1, 1957.

Dr. George T. Harrell Jr., Dean of the College of Medicine, together with Dr. Thomas expressed a wish for the continued close cooperation of the Florida Medical Association, the Florida State Board of Health, and the College of Medicine in the presentation of postgraduate medical education in the state.

The Committee approved continued efforts to elicit cooperation among all sources presenting postgraduate medical education to clear dates and to list their seminars with the office of the Florida Medical Association thereby eliminating, as far as possible, overlapping and conflicts of dates as well as duplication of seminars.

An exhibit stressing postgraduate medical education at the annual meeting of the Florida Medical Association was suggested to the Committee. Space was secured and various organizations throughout the state contacted for assistance in planning such an exhibit.

A ruling allowing medical postgraduate education to be deducted from the income tax made further action by the Committee in this regard unnecessary.

Plans for a Special Course in Hematology beginning on June 20, 1957 and for the 25th Annual Short Course, June 24-28, have been formulated. In compliance with the recommendation of the previous Committee, these courses will be held at the College of Medicine, University of Florida. Plans also are underway, at the request of the Florida Diabetes Association, for the presentation of a Seminar on Diabetes Mellitus during the Fifth Annual Meeting of this group scheduled for the fall at the College of Medicine.

The following courses were held during the year 1956:

Seminar on Cardiovascular Diseases, February 23-25, Jacksonville, with 120 in attendance.

Seminar on Gastroenterology, June 21-23, Jacksonville, with 44 attending.

24th Annual Short Course, June 25-28, Jacksonville, with 136 attending.

Seminar on Diabetes Mellitus, October 18-19, Jacksonville, with 74 registering.

Southeastern States Cancer Seminar, November 7-9, Jacksonville, with 85 registering for credit out of the 410 attending.

11th Annual Midwinter Seminar on Ophthalmology and Otolaryngology, January 14-19, 1957, with 370 attending.

"The report of the Committee on Cancer Control, Dr. Ashbel C. Williams, Chairman, is approved as printed in the Handbook.

"I move the adoption of this portion of the report."

Seconded by Dr. James R. Boulware Jr.

Motion carried.

Report of Committee on Cancer Control

Ashbel C. Williams, *Chairman*

The Committee on Cancer Control of the Florida Medical Association met jointly with the Florida Cancer Council, January 25, 1957, at Tampa, Florida.

It was the consensus that the chest X-ray remains the most accurate means for the early detection of lung cancer but that it is most effective when there is a direct patient-doctor relationship and where there is a patient selection on the basis of age and sex. Mass chest X-ray programs for early detection of lung cancer are not encouraged by this committee since they have proved impractical elsewhere in the country.

It was recommended that the hospitalization of indigent cancer patients be incorporated in the Plan for the Hospital Service for the Indigent provided that adequate funds be made available by the Florida State Board of Health for the continuation of other aspects of the cancer program including the support of tumor clinics, cancer seminars, cancer registries and other such projects as may develop in the future.

A subcommittee was appointed to study the distribution of tumor clinics in Florida and determine the need for, and location of, any additional clinics.

It was recommended that the Cross Roads Seminar be held again in the fall of 1958 and that this latter seminar be offered the Hillsborough County Medical Association for staging in Tampa. It was reported to the Committee that the Southeastern States Cancer Seminar held in Jacksonville in November, 1956, had a faculty of 19 outstanding cancer authorities and that the registered attendence was 425 physicians.

It was recommended that the American Cancer Society provide funds for and set up a program to aid and encourage the pathologists of Florida to take additional postgraduate training in exfoliative cytology. Also, it was recommended that a similar program be set up for the training of technician screeners in exfoliative cytology. The Committee feels that the above measures will greatly broaden and improve the quality of the cytodiagnostic facilities in Florida which is deemed a most important objective in cancer control.

The Committee recommended approval of a brochure prepared by the Florida Society of Pathologists at the request of the Florida Cancer Council. The brochure outlines information relative to the indications for obtaining and preparation of cytological smears. It also explains the clinical significance of the various types of pathological reports. It is for distribution to the physicians of the Florida Medical Association.

The Committee recommended approval of the principle of pilot cytological screening programs for cervical cancer and recommended the setting up of such a program in a Florida community.

"The report of the Committee on Venereal Disease Control, Dr. C. W. Shackelford, Chairman, is approved as printed in the Handbook.

"I move the adoption of this portion of the report."

Seconded by Dr. Jere W. Annis.

Motion carried.

Report of Committee on Venereal Disease Control

C. W. Shackelford, *Chairman*

Venereal diseases in the state appear to be under relatively good control. During the current year, there have been no sustained fluctuations in the trend which would indicate a rise or a greater than average decrease in the incidence of the five venereal diseases. About 1945, it was stated that there were more cases of venereal disease in Florida than any other state, and more cases in Bay County than any county in the state.

Through my office in 1956, a General Practitioner, 366 Kahns were made through the State Health Department, only fourteen positives were found; one primary, two early latent, eleven late latent and no congenital. Two proved to be spinal.

The first six months of 1956 there were 144 cases of primary and secondary syphilis reported by clinic and private physicians. The second six months there were 58 cases reported. The reduction in the cases for the second six month period may be due to reporting. However, infectious cases of most of the venereal diseases have shown a general decrease since 1950.

Gonorrhea is still the problem in venereal disease control. It is generally assumed that a large percent of gonorrhea is not being seen by private physicians, therefore, the cases are never reported. This can be explained by saying that many druggist are seeing and treating gonorrhea, not only by oral penicillin and sulfonamides, but also by disposable syringe penicillin. The State Health Department should investigate this, if legal. Reports from the Venereal Disease Control Committee state that they see about three cases a year.

Figures as reported by the State Board of Health follow:

	1950	1956
Primary and Secondary Syphilis	1510	202
Acute Gonorrhea	14185	10766
Chancroid	248	268
Lymphogranuloma Venereum	34	54
Granuloma Inguinale	446	72

Eleven counties have conducted selective intensive blood testing surveys during 1956. Simular programs are planned for eighteen other counties by June 30, 1957, remaining counties will have the same blood testing surveys.

In 1956, the state laboratories performed 190 TPI tests for private physicians. More should take advantage of this essential service. There is still a long way to go before most of the venereal diseases reach a control level or can be dismissed as a public health problem.

"The report of the Committee on Tuberculosis and Public Health, Dr. Phillip W. Horn, Chairman, is approved as printed in the Handbook.

"I move the adoption of this portion of the report."

Seconded by Dr. Madison R. Pope.

Motion carried.

Report of the Committee on Tuberculosis and Public Health

Phillip W. Horn, *Chairman*

During the year there were no outstanding problems nor questions presented to the committee requiring a formal meeting of the group.

Mr. W. T. Edwards of the State Tuberculosis Board requested an opinion as to the advisability of the continued "early discharges" of patients from the State Tuberculosis Hospitals. It was the belief that each patient should be individualized, and if facilities were available in his home community for follow-up and treatment, and if he was non-infectious, then this policy would be acceptable. In communities where the County Health Officer might seek consultation, then these services might be provided by the State Board of Health or the adjacent sanatarium staff.

In December 1956, The Florida Tuberculosis and Health Association initiated a state-wide coordinating Council on Tuberculosis to aid the official and voluntary groups interested in the care of the tuberculous patient to bring into common action a program that would benefit these persons. The various members of the health organizations, the medical association, the vocational service and the state Tuberculosis Board presented the problem. Definite recommendations are to be presented at the next meeting in the summer.

The "Shared Dietician" program was not brought up for discussion; apparently the number of dieticians interested in this type position is too small and also the hospitals are too widely distributed for this type of service to prove practical. The plan is excellent as it would provide smaller hospitals with well trained personnel both for supervision and training. It is felt that if there is sufficient demand the Florida Medical Association should approve the plan.

"The report of the Committee on Maternal Welfare, Dr. E. Frank McCall, Chairman, is approved as printed in the Handbook.

"I move the adoption of this portion of report."

Seconded by Dr. Chas. J. Collins.

Motion carried.

Report of Committee on Maternal Welfare

E. Frank McCall, *Chairman*

The Maternal Welfare Committee has had three planned meetings for discussion; two in Miami during the Florida Medical Association meeting and one in Daytona Beach. One of our members, Dr. Richard

Stover, has met in a joint meeting with the American Committee on Maternal Welfare in Hollywood. The Maternal Welfare Committee sponsored by the State Boards of Health of Florida, Georgia, and South Carolina, held an Obstetric and Pediatric Seminar at Daytona Beach September 10, 11, and 12. This meeting is showing a progressive yearly increase in attendance. Total registration was 323. The faculty for this meeting was as follows:

Dr. Fred Adair, Maitland, Florida;
Dr. William J. Dieckmann, The Chicago Lying-In Hospital;
Dr. John Parks, The George Washington Univ. School of Medicine;
Dr. Charles H. Hendricks, University Hospitals of Cleveland;
Dr. Milton L. McCall, Louisiana State University School of Medicine;
Dr. Georganna Jones and Dr. Howard Jones, Johns Hopkins Hospital;
Dr. Frederick H. Falls (Visitor) Chicago, Illinois;
Dr. Sydney S. Gellis, Childrens' Hospital, Boston;
Dr. James G. Hughes, University of Tennessee;
Dr. Edith L. Potter, The Chicago Lying-In Hospital;
Dr. Robert Lawson, University of Mlami.

Plans are now in progress to again hold this meeting in Daytona Beach in 1957.

The State Board of Health has not compiled their final figures for the maternal deaths in Florida up to this date, but with the figures we have at hand, we know that there has been an increase in the total number of deliveries, and that the maternal mortality for the state will be approximately the same as 1956. That is, 5.5 per 10,000, which is below the national average.

We are again deeply grateful for the help we have received from our sponsors. I would like to thank each member of the committee for their complete cooperation during this past year, and also our President, Dr. Francis H. Langley, for his cooperation during the entire year.

"The report of the Committee on Child Health, Dr. Warren W. Quillian, Chairman, is approved as printed in the Handbook.

"I move the adoption of this portion of the report."

Seconded by Dr. James R. Boulware Jr.

Motion carried.

Report of Committee on Child Health

Warren W. Quillian, *Chairman*

The Committee on Child Health has served during the past year as an advisory group with the Florida Pediatric Society and the Florida Chapter of the American Academy of Pediatrics. Efforts have been largely in the promotion of organized programs throughout the state for poisoning control among children, and in a coordinated effort to facilitate the availability and distribution of poliomyelitis vaccine. Considerable effort has been expended in this connection in collaboration with the Florida State Board of Health, under the able leadership of Dr. Wilson T. Sowder.

In an attempt to reduce accidental poisoning among the children of this state, the Florida Pediatric Society has established Centers at fifteen strategic locations throughout Florida. These are serving as emergency stations for diagnosis and therapy under the supervision of local physicians. By means of an educational program, these Centers are designed to become sources of factual information concerning industrial and agricultural hazards which may be potential sources of poisoning in children.

We were represented in January, 1957, at a meeting of the Committee on Maternal and Child Care of the Council on Medical Service of the American Medical Association at Hollywood Beach. It is the general consensus that improvement of morbidity and mortality rates during neonatal life depends now upon better technics and skills during the prenatal as well as the postnatal periods. A guide for maternal death studies, now being prepared for distribution by the American Medical Association, should be helpful in the attack on problems related to this field of child care. Better cooperative effort among general practitioners, obstetricians and pediatricians will inevitably result in the reduction of perinatal mortality.

Programs for continuing health supervision of children from birth through the school years were discussed. It is hoped that these programs can be accomplished through effective contact with the child's own medical adviser, his personal physician. Most of the problems of child health are best managed at the local level, with the aid and support of physicians through their local medical society. Much of our work has been initiated by others. We are glad to provide guidance and supervision when requested. Our chief purpose as a Committee is to promote activities designed for improvement of the health and care of Florida's infants and children. These activities are sponsored by and through existing agencies since no funds have been allocated for a state-wide organized effort by our Committee. Needless reduplication of effort is thus avoided. Committee personnel is selected from each medical district.

"The report of the activities of the State Board of Medical Examiners, Dr. Homer L. Pearson Jr., Secretary, is approved as read.

"Mr. President, I move the adoption of this portion of the report.

Seconded by Dr. James N. Patterson.

Motion carried.

Report To: Florida Medical Association, House of Delegates

From: Florida State Board of Medical Examiners

Submitted by: E. B. Hardee, M.D., President, Homer L. Pearson Jr., M.D., Secretary

We are happy to again make a short report of the activities of the Board of Medical Examiners.

During the past year we examined 723 applicants, 544 of whom were issued certificates of licensure. There was a mortality rate of 24.6%. We revoked 1 license and suspended 2. It may be of interest to you to know that only the Board can suspend or revoke a license; however, we have no authority to reinstate a revoked license. To regain a license one must re-apply and pass the examinations again—if accepted for examination. We can find no fault with that procedure.

There are certain of the specialty groups who feel that the examinations are not quite fair to them, since they must pass examinations prepared primarily for the general practitioner and many times there are no questions pertaining to their particular specialty, which if asked would give the applicant an opportunity to bring his general average up. The Board has considered this complaint and will try to have a few questions covering the entire field of medicine, surgery, and we may add psychiatry.

The president and secretary of the Board have been attending regularly the meetings of the Federation of State Medical Boards of the United States where problems common to all boards are studied. We would like to call your attention to one or two of these problems.

1. Are examinations by the several state boards any longer justified? Much can be said pro and con on this subject, but it contains much food for thought. There are now no unaccredited medical schools in the United States. All graduates of these schools are declared fit by the schools to be doctors. Each one will be granted license in one or more states. Most examining boards follow a similar pattern in examining and grading. If a man will not make a fit doctor he should never be permitted to graduate. If he is a fit doctor then he should be permitted to practice anywhere he wishes, say some. A man is actually not a fit doctor when he graduates but needs hospital or other training before he is, so the board examinations should cover an area above that covered by school examinations and below that covered by the specialty boards, or should be aimed at those who have had at least one year internship, say others. Yet, Florida has no internship requirement. There are some who believe our principle function now is to regulate the distribution of doctors. However, it is easy to see the difficulty in so far as the state itself is concerned. Once a license is granted we have no control over where in the state one may locate. There can be too many doctors in Fort Lauderdale and too few in Okeechobee but just try to get somebody to move from Fort Lauderdale to Okeechobee! Then too, it is very difficult to convince the mother who cannot get a doctor to see her baby in the middle of the night, or people living in a county that has no doctor, that there is not a shortage of doctors in Florida.

2. Another frequently discussed question is that of national endorsement as opposed to reciprocity or no reciprocity. We believe that all states except Florida now have some degree of endorsement. We have used the age old excuse that if we became more liberal and granted license other than by examination we would be flooded by doctors. That statement has been questioned by some. The examinations certainly create a stumbling block for many. Endorsement does not mean the indiscriminate acceptance of all who hold licenses in other states but that under certain conditions he may be accepted for license without examination. California will accept certain ones without examination if they have passed the endorsed state board examinations in the past five years. Of course, the question of whether we should grant license through any form of endorsement is one which the doctors of this state should decide.

3. Another of the pressing questions has been about what to do with foreign graduates. For a number of years the Council on Medical Education and Hospitals of the American Medical Association has published a list of the acceptable foreign medical schools. We feel that some on this list should not be and many which are not there should be, yet, the American Medical Association could not inspect all foreign medical schools. Especially if they have not been invited to do so. From now on a different approach is to be made to the problem. A committee has been set up representing the American Medical Association, American Hospital Association, Federation of State Medical Boards of the United States, and others, called the "Educational Council for Foreign Medical Graduates." The purpose of this group is to screen every foreign graduate who comes to the United States and if his education comes up to standard for the United States he is recommended to the state boards. There is no obligation of the part of the board to accept him but he has a clean bill of health as far as his medical education is concerned. The American Medical Association will then no longer accredit or discredit any foreign school.

Finally, since the Florida Medical Association, of which each member of the Board of Medical Examiners is a part, has as one of its aims the improvement of medical care for our people. We are of the opinion that the Board of Governors of the Florida Medical Association should act as an advisory committee to the Board of Medical Examiners. We feel that in this way our Board can be in closer touch with the general membership of the Florida Medical Association and that any recommendation for changes in the medical practice act and in the conduct of the affairs of the Board would more definitely come from the medical profession of this state as a whole.

"Mr. President, I move the adoption of the report as a whole.

Seconded by Dr. Meredith Mallory.

Motion carried.

Other members of this committee were Drs. C. Frank Chunn, of Hillsborough, V. Marklin Johnson, of Palm Beach, Charles R. Sias, of Orange, and Paul F. Baranco, of Escambia.

Report of Reference Committee No. 2

The Chair called for the Report of Reference Committee No. 2, Public Policy, by Dr. Chas. J. Collins, Chairman.

Dr. Collins: "Mr. President and Members of the House of Delegates:

"Your reference committee gave careful consideration to items referred to it and makes the following report:

"The report of the Committee on Conservation of Vision, Dr. Charles C. Grace, Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Walter C. Jones.

Motion carried.

Report of Committee on Conservation of Vision

Charles C. Grace, *Chairman*

The Committee on Conservation of Vision in cooperation with the Florida Council for the Blind is in the process of making a survey of the educational facilities offered throughout the state for the blind and partial-seeing children.

This information will be correlated and printed in pamphlet form. It will be available to all state residents who desire and who write to the Florida Council for the Blind.

"The Committee carefully considered the report of the Committee on Medical Education and Hospitals together with the supplemental report and the additional report of the Medical Schools Liaison Committee. The Committee recommends that point 6 of the original Committee report read as follows: 'That a Liaison Committee be established as a sub-committee of the Committee on Medical Education and Hospitals. This committee shall be appointed by the President of the Florida Medical Association and shall consist of seven members to be selected as follows:

a. One member from the medical faculty of the University of Miami School of Medicine and one member from the

medical faculty of the University of Florida College of Medicine.

b. One member of the Dade County Medical Association and one member of the Alachua County Medical Society.

c. One member from each of the other two medical districts of the Florida Medical Association other than where the medical schools are located, and one member from the Florida Medical Association at large.' "

"The Committee recommends that the last sentence of the supplemental report, which reads 'Therefore, this committee again recommends to the House of Delegates that serious consideration, and action, be given to the idea of each member of FMA donating $10 each year to the AMEF' be changed to 'This committee recommends to the House of Delegates that each member of the FMA be encouraged to donate $10 or more to the Florida Medical Foundation to be used for whatever purpose he designates as defined in the Charter.' "

"The Committee recommends that paragraph 5 of the Report of Medical Schools Liaison Committee be deleted.

"Mr. President, I move that these portions of the report be adopted as amended with commendation to Dr. Walter E. Murphree and his committee for their fine work."

Motion seconded.

Dr. James L. Anderson: "I would like to say something in favor of Dr. Murphree's original report. I feel he has a better idea than has been suggested. There are several reasons; one of which is that the county medical society, with all due respect to our president, is more likely to appoint a man to represent the county who could successfully iron out differences between the medical school and the local medical profession than could a man who was appointed by the president of the association, who might be someone residing in another locality who was not familiar with the local problem."

Dr. Collins: "Our committee discussed that phase of the problem. There will also be a committee on liaison with medical schools on the county level, and it was felt that most of these problems will be solved by the county committee on the local level. It was also taken for granted that the President, in appointing his committee, would consult the respective county medical societies and obtain their advice in selecting a member to represent that county society."

Motion carried.

Report of Committee on Medical Education and Hospitals

Walter E. Murphree, *Chairman*

At the 1956 meeting of the Florida Medical Association the Alachua County Medical Society presented a resolution on the Relationship Between Medical School Faculties and Physicians of the Community. The House of Delegates approved this resolution in spirit and referred it to the Committee on Medical Education and Hospitals to act in conjunction with the Medical Advisory Committee of the University of Florida, with instructions to report to the Board of Governors in September.

This was a new experience for the Committee on Medical Education and Hospitals as, in the past, its efforts have been limited to seeking donations to the AMEF and of publicizing the aims of the AMEF. Intensive study was made on the subject of medical school faculties, especially of the report on "Private Practice by Medical School Faculty Members," presented to the House of Delegates of the American Medical Association by the Council on Medical Services. This report contains detailed surveys from both medical school deans and state and county medical associations and was made available to all members of the Committee for their study.

On August 5, 1956, a combined meeting of the two committees, to which the question had been referred, was called in Gainesville, Florida. After considerable study and discussion of the problem, the following was recommended to the Board of Governors at its September meeting:

1. That the action of the American Medical Association House of Delegates, June, 1956, in adopting the Culpepper resolution is accepted.
2. The adoption of that section of the American Medical Association House of Delegates action in June, 1956, dealing with publicity.
3. That it be the primary responsibility of the administrators of medical schools to exercise adequate controls over the extent of private practice in order to maintain proper relationship between teaching responsibilities and private practice.
4. See No. 3 of Report of Medical Schools Liaison Committee, page 45.
5. That a Liaison Committee be established as a subcommittee of the Committee on Medical Education and Hospitals. This Committee shall be appointed by the President of the Florida Medical Association and shall consist of seven members to be selected as follows:
 a. One member from the medical faculty of the University of Miami School of Medicine and one member from the medical faculty of the University of Florida College of Medicine.
 b. One member of the Dade County Medical Association and one member of the Alachua County Medical Society.
 c. One member from each of the other two medical districts of the Florida Medical Association other than where the medical schools are located, and one member from the Florida Medical Association at large.
6. That the appointments to the Liaison Committee should be made for four years and the initial terms to be staggered to provide for a minimum change of members in any one year.
7. That the function of this Committee to be in line with those recommended in the report adopted by the American Medical Association House of Delegates, June, 1956.

The action of the Board was to approve the report of the committee with the exception of No. 5, which states,

"That an appropriate limit of 'take home pay' be set for geographical full-time faculty members by the Medical School Deans." The Board directed that the Liaison Committee, as authorized by this action, study this particular recommendation further, investigate it, and recommend such changes as were deemed advisable.

The membership of the Liaison Committee is now complete and is as follows:

Dr. Walter E. Murphree, Gainesville, Florida—State at Large

Dr. Merritt R. Clements, Tallahassee

Dr. Henry H. Graham, Gainesville

Dr. James N. Patterson, Tampa

Dr. Edward W. Cullipher, Miami

Dr. Homer F. Marsh Jr., University of Miami Medical School

Dr. George T. Harrell Jr., University of Florida Medical School

This Committee will meet in the near future and should have a supplementary report for the House of Delegates.

The action of this Committee in behalf of the AMEF has been limited to correspondence. The total donations for 1956 is not available at this writing. The quota for the State of Florida was $20,000. Dr. Jack Cleveland, the previous chairman of the Committee, attended a meeting of state chairmen of Medical Education Committees on January 27, 1957. This has been an annual meeting for Dr. Cleveland for several years. His comments in regard to this national meeting, as a representative of this Committee, will be made in a supplemental report.

Supplement

The American Medical Education Foundation was organized and sponsored by the AMA in 1951 to seek financial contributions in behalf of the medical schools. The medical profession's annual goal is $2,000,000, which goal has not as yet been met in any one year.

AMEF State of Conditions, Dec. 31, 1956

Amount transferred to National Fund for Medical Education and distributed to Medical Schools since 1951		$4,684,312.00
Amount available for distribution Dec. 31, 1956		1,072,727.00
Total Income—1951 to date		5,757,039.00
1956 Source of Income		
Physicians	$ 534,074.51	
AMA	225,000.00	
Other societies, organizations and clinics	216,623.47	
Woman's Auxiliary and laymen	90,988.89	
	$1,066,686.87	
Interest	6,040.13	
TOTAL		$1,072,727.00

The Fifth Annual Report of the foundation shows that of the 2980 Florida physicians, 57 contributed to the Foundation in 1955 or 1.9%. Their contributions amounted to $4,799.00. During the same period 640 Florida physicians made financial contributions totaling $19,558 directly to the alumni programs of their own schools. In 1956 only 73 of Florida's approximately 3,000 physicians contributed to AMEF, with a total of $4,640.00. Only 13 other states in the union contributed less than Florida. These statistics prove that Florida physicians need to be educated as to the needs of the AMEF. Florida's equitable quota of the national whole is estimated to be $20,000.00, and the AMEF campaign would be a success if each member contributed a minimum of $10 toward this quota. It is felt that this idea would meet with success for there have been almost sixty contributions of $10 or $20 for members of the FMA in the months of January and February 1957.

This committee recommends to the House of Delegates that each member of the FMA be encouraged to donate $10 or more to the Florida Medical Foundation to be used for whatever purpose he designates as defined in the Charter.

Report of Medical Schools Liaison Committee

Walter E. Murphree, *Chairman*

This Committee met in Gainesville on March 31 to consider the question referred to it by the Board of Governors. All members were present with the exception of Dr. Edward W. Cullipher, representative of Dade County, and Dr. George T. Harrell, who was represented by Dr. Sam Martin.

The meeting was a harmonious one, and it was pleasant to note that the thinking of the two medical schools in regard to earned remuneration for geographic faculty members was almost identical. We think that this augurs well for the future relationships between the schools and the members of FMA. The consensus of the committee was that it would be impossible for this committee to spell out in dollars and cents the salaries of the various faculty members because of the many variables involved, especially in the keeping of a proper ratio between associate professors and heads of departments for instance, and the supplementation of salaries of basic science instructors who would have no opportunity to supplement their own salaries. The idea of allowing one to make 100% of one's base salary was not found objectionable in principle, but impossible to apply practically. It was agreed that in the implementation of this problem there would of necessity have to be a good deal of faith in one another and in one another's principles. There was no evident lack of such faith at this meeting. Therefore, the committee's formal report and recommendations to the Board of Governors are as follows:

1. That the limit of "take home pay" be set for geographic full time faculty members by the Executive Committees and Deans of the medical schools, with the full knowledge of the Medical Schools Liaison Committee, which subject shall be an item on the agenda of the committee at its semi-annual meetings.
2. That the Medical Schools Liaison Committee shall meet twice yearly to consider any problem that might arise in such liaison.
3. That recommendation No. 4 of the Report of the Committee on Medical Education and Hospitals of August 6, 1956 shall read: "That all patients treated in medical school facilities be used for teaching purposes. That all private patients treated by geographic full time faculty members must be referred by a licensed physician.
4. That the Board of Governors be requested to ask County Medical Societies where medical schools are located to establish a liaison committee of not more than three members to meet with an equal number to be appointed by the Dean of the Medical School. The purposes of these committees to be essentially the same as the state committee, though on a local level, and to cooperate with the state committee.

"The report of the Committee on Medical Economics, Dr. Robert E. Zellner, Chairman is approved as printed in the Handbook.

"The Committee wishes to stress the importance of the enrollment of at least 60% of the members of the Florida Medical Association in the insurance plan, so that it may be available to all members. The Committee further wishes to commend the Chairman, Dr. Robert E. Zellner, and his committee for their work.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Walter C. Jones.

Motion carried.

Report of Committee on Medical Economics

Robert E. Zellner, *Chairman*

The work of the Medical Economics Committee this year has been a continuation of projects previously initiated. The Association's first group insurance endeavor was begun with the offering of its Disability Insurance and Catastrophic Hospitalization plans. The effective date of the plan was delayed some six weeks by complaints to the Insurance Commissioner by the Florida State Association of Health and Accident Insurance Underwriters. The plan was re-examined by the Commissioner and, after minor changes suggested by the Attorney General, offered to the members of the Association.

Florida law requires that sixty percent (60%) of the membership of an organization must participate in an insurance program before it can qualify as a true group. To date only about thirty percent (30%) of the membership of the Association has applied. Until this percentage figure is reached, it is necessary for the underwriter to consider each individual application. This means that those with unfavorable past medical histories will not be accepted. As soon as the required sixty percent (60%) participation is met, all rejected applicants will be invited to re-apply for insurance and all restrictive riders on any issued policies will be removed.

The Committee urges that all members of the Association carefully study the advantages of the Association plan and that all those who intend to purchase this insurance do so promptly in order that the benefits of this insurance may become available to those of our members who are otherwise uninsurable.

This past year witnessed the first raise in rates for professional liability insurance since 1952. The Association has successfully resisted three previous attempts on the part of the National Bureau of Casualty Underwriters to obtain rate increase. On Oct. 8, 1956, the Insurance Commissioner held a meeting in Tallahassee for the purpose of ascertaining the justice of the Bureau companies' request for rate increases. Despite a very spirited and effective presentation of the medical profession's attitude on this matter by Mr. Frank Kelly, jointly representing the Florida Medical Association and the Dade County Medical Association, the Commissioner granted an eighty-seven percent (87%) increase in professional liability rates for physicians and one hundred thirteen percent (113%) increase for surgeons.

The Chairman feels that despite the rate increases, this meeting accomplished two things:

1. It afforded the opportunity for the profession to present to the Commissioner and the National Bureau Companies its dissatisfaction with the way malpractice claims and professional liability insurance are being handled in Florida. Representatives of 27 of the 37 county medical societies representing seventy-five percent of the membership of the Association were present at the meeting.
2. For the first time, the insurance companies recognized that the Association, and not just the individual physicians, has some interest and should have a voice in matters related to malpractice.

The latter point was further emphasized when a Committee from the Association of Casualty Companies at the urging of the Insurance Commissioner, requested a meeting with representatives of the Association. The Medical Economics Committee met with this Committee on Nov. 4, 1956, in Jacksonville. The insurance representatives agreed to urge their members and their companies to seek the assistance of the Florida Medical Association and the various county medical society insurance committees whenever claims of malpractice arose and to request the claim men's associations throughout the state to have representatives from the Association to speak at their meetings on the medical Association's program.

The Committee urges that those county societies which have not yet organized insurance committees do so soon. The practice which some county societies have of including a discussion of medical ethics, grievance committee activities, and malpractice in their indoctrination program for new members is heartily endorsed and recommended to all county societies.

The chairman wishes to express his appreciation to the members of the Committee, to Dr. Day, Dr. Langley, and to Mr. Gibson for their help and advice.

"The report of the Committee on Representatives to Industrial Council, Dr. Chas. L. Farrington, Chairman, is not approved.

"It was noted in this report that the chairman recommended that this committee be discontinued. The Committee felt that this was not wise because of many future problems which will arise due to growth of industry in the state. It is felt that this committee could work to better advantage if its duties were more clearly defined.

"Mr. President, I move that this portion of the report be not approved and not published in The Journal."

Seconded by Dr. Leffie M. Carlton Jr.

Motion carried.

"The report of the Grievance Committee, Dr. David R. Murphey Jr., Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Charles R. Sias.

Motion carried.

Report of the Grievance Committee

David R. Murphey Jr., *Chairman*

As has been the custom since the formation of this Committee, one meeting is held each year in conjunction with the meeting of the State Association. The last meeting was held at the Fontainebleau Hotel under the chairmanship of Dr. Herbert E. White. The next meeting will be held at the Hollywood Beach Hotel, at the 1957 Annual Meeting of the Association.

It has been the policy of the State Committee to refer all complaints to the local county grievance committees and these committees have functioned efficiently and promptly during the past year.

The number of complaints received this year has not increased over the past year. The types of complaint vary and those that are not obviously from psychopathic personalities, arise from misunderstanding between the patient and physician, usually over the fee. There are only two or three hold-over complaints that have not been settled.

As Chairman of the Committee I want to thank the other members for their cooperation and especially the local county grievance committees for their prompt attention to complaints arising in their localities.

"The report of the Committee on Nursing, Dr. Jere W. Annis, Chairman, with its supplemental report, is approved.

"I move the adoption of this portion of the report."

Seconded by Dr. James T. Cook Jr.

Motion carried.

Report of Committee on Nursing

Jere W. Annis, *Chairman*

The Committee on Nursing met in the Roosevelt Hotel at Jacksonville Nov. 4, 1956, immediately following a called meeting of the House of Delegates.

Numerous reports from the county medical societies regarding the appointment of committees on nursing were at hand and apparently each society has appointed an individual or a group to deal with local nursing problems.

Communications from various societies were considered and the advisability of consideration by this Committee of unsolved local nursing problems was discussed. Several societies availed themselves of the opportunity of having representatives present at the meeting. No other business of significance was transacted.

No specific Committee action has been taken on any nursing problems. Local committees in the various county societies have been established, and it is hoped that any problems affecting nursing and the medical profession will be funnelled through these committees to the State Association.

Supplement

In mid-April a part of the Committee met in Tallahassee with members of the nursing profession who were about to introduce into the State Legislature amendments to the Nursing Practice Act. These amendments were in many respects inimical to the best interests of the medical profession and concerned chiefly the regulation of the physician's office assistant as well as the limitation of the scope of activity of the licensed practical nurse.

The Committee was successful in effecting the deletion of all objectionable features from the Bill which was then approved and which has since been reported out of committee in both Houses of the Legislature.

"The report of the Committee on Blood, Dr. Louis E. Pohlman, Chairman, is approved as printed in the Handbook.

"I move the adoption of this portion of the report."

Seconded by Dr. James N. Patterson.

Motion carried.

Report of Committee on Blood

Louis E. Pohlman, *Chairman*

The Committee chairman represented Florida in a panel discussion on "Blood Procurement in a Civil Defense Disaster" held by the Federal Civil Defense Administration at Fort Benning, Georgia, August 13, 1956. The unrealistic criteria and standards regarding equipment, staffing, as well as blood needs, was pointed out. The need to impress "Type O" blood donors as to the importance of their blood was expressed. This fact is doubly important when it is realized that only "Type O" blood will be collected during the first 72 hours of any disaster.

The Florida Association of Blood Banks held a Directors meeting in Miami during December. It was decided to hold the annual meeting at a time when many doctors attending the Florida Medical Association meeting could also attend the blood banks meeting. This time was to be in May just following the F.M.A. meeting.

Medicare

The future of blood procurement in regards to the new Medicare Plan has not been determined. The efforts of most health insurance groups has been to buy blood outright and without regard to replacement. The Prognosis for the Community Blood Bank is not good with the symptoms now beginning to be observed along with the inroads of socialized medicine.

The Joint Blood Council has failed to assume a positive role in coordination of blood collecting facilities on a national scale and thereby allowing a lay group to contract for collection of blood for civil defense. A.M.A. representatives to the Council have been content to observe recent activities within the federal government. A new coordinating committee on blood in the Office of Defense, the National Research Council's Committee on Blood and a blood procurement section of O.D.M. may well reach the objectives outlined by the recently formed Joint Blood Council.

"On the resolution on Non-cancellable Health and Accident Insurance Policies, presented by the Escambia County Medical Society, I move this resolution be approved in principle and referred to the Committee on Medical Economics."

Seconded by Dr. Paul F. Baranco.

Motion carried.

Resolution

Non-Cancellable Health and Accident Insurance Policies

WHEREAS certain insurance policies do not clearly state on the face of the policy as to whether or not the policy is "cancellable" or "non-cancellable" and "guaranteed renewable," and that certain health and accident insurance policies are cancelled at the discretion of the insurance carrier, be it therefore resolved that our Delegates introduce a resolution to the Insurance Committee of the Florida Medical Association that they work toward legislation which would clearly mark health and accident insurance policies on the face of the policies in large letters as to whether or not the policy is "cancellable" or "non-cancellable," "guaranteed renewable" or "not guaranteed renewable," and that such policies which had been in continuous effect for a 3 year period cannot be cancelled at the discretion of the company, as long as the premiums are paid.

Resolution adopted by The Escambia County Medical Society on April 9, 1957.

Respectfully submitted
Pascal G. Batson Jr., *Secretary*
Escambia County Medical Society

"Mr. President, I move the adoption of the report as a whole."

Seconded by Dr. Mallory.

Motion carried.

Other members of this committee were Drs. S. Carnes Harvard, of Pasco-Hernando-Citrus, Burns A. Dobbins Jr., of Broward, James T. Cook Jr., of Jackson-Calhoun, and Leffie M. Carlton Jr., of Hillsborough.

Report of Reference Committee No. 3

The Chair called for the report of Reference Committee No. 3, Dr. Norval M. Marr Sr., Chairman.

Dr. Marr: "The report of the Board of Governors as printed in the Handbook and the supplemental report are approved, with the exception of those portions of the supplemental report which were referred to other reference committees.

"I move that this portion of the report be approved."

Seconded by Dr. Mallory.
Motion carried.

Report of Board of Governors

Francis H. Langley, *Chairman*

During the administrative year and prior to the publication of this report, three regular meetings of the Board were held on May 16, September 16 and January 27. In addition the Board met in called session on August 18, 1956 to consider methods and procedures for implementation of the Dependents' Medical Care Act, Public Law 569, 84th Congress, known as the Medicare program. Another meeting has been scheduled tentatively for April prior to the meeting of the House of Delegates and will be covered in a supplemental report.

Every member of the Board merits high commendation for his willingness to sacrifice time and convenience to attend these meetings at personal expense. It is indeed stimulating to note the sincerity, thoroughness and wisdom with which the Board considers an astonishing variety of problems to the benefit of every member of the Association. I wish to take this opportunity to express my personal gratitude to the members of the Board and express on behalf of the Association deep appreciation for this service and devotion.

Recommended By-Law Changes

Committee on Emergency Medical Service

A Committee on Emergency Medical Service has been in existence for several years, but has not been officially designated as a standing committee with appointments in the same manner as other committees. It now appears that this, or similar committee, will probably need to function in the foreseeable future. It is therefore recommended that the following by-laws changes be effected:

CHAPTER VII—Sec. 1. In line 23 following the term "(Section 20)", the period shall be replaced by a semicolon and the following added, "a Committee on Blood (Section 21); a Committee on Nursing (Section 22); a Committee on Emergency Medical Service (Section 23)."

In line 25 the term "(Section 21)" shall be changed to read "(Section 24)". In line 28 the term "(Section 22)" shall be changed to read "(Section 25)."

CHAPTER VII—Sec. 23 be changed to:

> "Emergency Medical Service, Appointment and Duties" — The Committee on Emergency Medical Service shall consist of five members. The President shall appoint four members, one from each medical district, one for one year, one for two years, one for three years, and one for four years, and thereafter they shall be appointed for four years as the terms expire. The President shall also appoint one member at large for a term of one year. The President shall select as chairman of this committee one of the five members, who shall serve in that capacity for one year. The duties of this committee shall be to cooperate with the Federal Civil Defense Administration, and particularly with the State Civil Defense Administrator and State Civil Defense Medical Officer in an advisory capacity; to act in an advisory capacity to the Red Cross in matters of civil defense and disaster, and to encourage the establishment and assist in the functioning of similar committees in each county medical society; and, in the event of a disaster, to aid in the moving of medical personnel to the disaster area in numbers consistent with the need.

The Chairman of the Committee on Emergency Medical Service is recommending in his report that the name of this committee be changed to Civil Defense and Disaster Committee.

"Sec. 23. (1956 Revision) Board of Past Presidents" be changed to read "Sec. 24. Board of Past Presidents."

"Sec. 24. (1956 Revision) Arrangements for Annual Meeting" be changed to read "Sec. 25. Arrangements for Annual Meeting."

Recommendation
Annual Meeting Sites

1958—Americana, Bal Harbour

The 1956 House of Delegates approved a recommendation of the Board of Governors that the 1958 Convention be held in Jacksonville, contingent upon completion of additional hotel facilities. It now appears that these additional facilities may not be available in time for the 1958 meeting. It is, therefore, recommended that the House of Delegates reconsider its action in selecting Jacksonville as the site for the 1958 Convention and designate in its place the Americana in Bal Harbour.

The By-Laws provide that the Board of Governors shall set the dates for these meetings. Your Board wishes to call to your attention that the Americana is holding the dates of May 10 through May 14, 1958 pending action by this House. These are the earliest dates available to us in that year.

1959—Undetermined

As this handbook goes to press, it is known that additional hotel facilities in Jacksonville will be available in the near future. At this time it is impossible to determine the earliest dates these will be available, the extent of these facilities and whether they will be adequate for our meeting. It is requested that the Board of Governors be authorized to select Jacksonville as the 1959 Convention site, if in its opinion adequate facilities are available. If it becomes necessary to make another selection, recommendations to that effect will be presented to the House at the 1958 Annual Meeting.

Your Board earnestly requests that members or county medical societies believing convention facilities in your area adequate and desiring to have the meeting in your community so advise the Board in order that these facilities may be inspected to determine whether they be adequate.

Number one project for the year was the completion of the new permanent home for the Association at 735 Riverside Avenue, Jacksonville. Your beautiful new building of contemporary design was occupied for the first time on August 15. It was formally dedicated on September 15. The efficiency of your executive office has been greatly improved and expansion of service to the members is made possible by the enlarged and improved physical plant. Not only has the Board met in the new building but it has been utilized on numerous weekends by allied and ancillary organizations for committee meetings. Every member is urged to visit the headquarters building in Jacksonville to observe personally the facilities which you have provided for your association. A deep debt of gratitude goes to the Building Committee, Dr. Edward Jelks, Chairman, Dr. Robert B. McIver and Dr. Samuel M. Day.

The final recommendation of the Building Committee just prior to being discharged at its own request was the placing on one of the walls of the Board Room a photograph accompanied by suitable inscription of the late Dr. Stewart G. Thompson, Managing Director of the Association, 1926-1953.

Another major activity during the year, which has made, and continues to make, great demands on the time of Board members and the executive office is the Medicare program. Following the lead of the American Medical Association, and acting under its recommendations from planning on a national level, a contract with the Federal Government was accomplished within the limitations set by the House of Delegates at a called meeting in Jacksonville on November 4, 1956. Acting on your authority, Dr. John D. Milton negotiated a fee schedule on the basis of the California Relative Value Schedule within your conversion factor limitations. Copies of a brochure containing this fee schedule, known as the Schedule of Allowances, and other essential information was mailed to each member of the Association in late January. Blue Shield of Florida, Inc. in compliance with your request is a party to the contract with the Government to serve solely as the fiscal administrator. In accordance with the provisions of the contract, a Medicare Mediation Committee has been appointed. This committee will hear complaints, re-

view special reports and recommend fees for unlisted procedures. Further, in accordance with a directive of this House, a committee to study the Medicare fee schedule to submit recommendations as a basis for the renegotiation of the present contract, which expires June 30, has been appointed. A listing of the members of this committee, selected from the major categories of medicine, surgery, radiology, pathology and general practice, may be found in the committee section of The Journal.

An operating budget for the fiscal year beginning March 21, 1956, in the amount of $141,848 was presented by Dr. Samuel M. Day, Secretary-Treasurer. To this was added $1,400 authorized by the Board for salary adjustments, $2,500 directed by the House of Delegates to reimburse the President and Secretary-Treasurer for travel expenses and $600 for expenses of delegates to the Student American Medical Association, making a total budget for the fiscal year of $146,348. This budget was based on experiences during the fiscal year as reflected in the audited joint financial statement of the Secretary-Treasurer and Managing Director, published in the July 1956 Journal. It is anticipated that reports and financial statements for 1957 will be published in the July 1957 Journal.

As authorized by the 1956 House of Delegates, an Executive Committee of the Board of Governors was established and has proved of inestimable value in long range planning and the study of involved problems for recommendations to the Board.

During the year, the Florida Medical Foundation authorized by the 1956 House of Delegates was organized. A Charter was drawn up and approved by the Judge of the Circuit Court. This Charter designates members of the Board of Governors as the members of the Foundation. By-Laws were then drawn up and approved by the Board of Governors, and in accordance with the provisions of the Charter officers of the Foundation were elected. They are: Drs. Edward Jelks, President, John D. Milton, Vice President, and Clyde O. Anderson, Secretary-Treasurer. Additional information on the Foundation and methods by which contributions may be made to it will be presented to the members in the near future.

Your Board gave approval to the recommendation of the Committee on Medical Education and Hospitals, Dr. Walter E. Murphree, Chairman, of the establishment of a Committee on Liaison with Medical Schools. Details of this are contained in Dr. Murphree's report.

Upon the recommendations of the Executive Committee and the Chairman of the Scientific Work Committee, Dr. George T. Harrell Jr., your Board carefully considered and approved with commendation the schedule and program for the Eighty-Third Annual Meeting. This schedule as published in the April Journal and as contained in the official program, contains certain changes and innovations, including the first meeting of the House of Delegates at 3 p.m., Sunday, May 5. It is believed that this arrangement has definite advantages which will improve the meeting and will increase the efficiency of the House of Delegates by allowing Reference Committees more time to consider reports and resolutions. It will also make possible for current delegates to be seated at the Annual Meeting of Blue Shield.

An innovation to the scientific program is a closed circuit television panel program sponsored by Smith, Kline & French Laboratories. The program will originate in Chicago and the state associations of North Carolina, Louisiana, Oklahoma and Kansas, who are meeting simultaneously will be included in the hook-up. This is scheduled for 3 to 4 p.m., Monday afternoon, and our portion of the program will be moderated by Dr. Robert J. Needles, of St. Petersburg. Any member of the television audience may submit questions to the panel by telephone during the course of the telecast.

Due to the fine facilities available in the motion picture theater at the Hollywood Beach Hotel, scientific motion pictures have been scheduled for Monday night, May 6.

Your Board has been kept advised of the progress of the disability insurance program, details of which may be found in the report of the Chairman on Medical Economics, Dr. Robert E. Zellner. Members of the Association who have not already done so are encouraged to investigate the coverage offered in this program under sponsorship of the Association. It is only when the required participation is reached that it will be possible for all members of the Association under age 70 to be eligible for disability insurance regardless of medical history.

Your Board took under advisement and careful consideration a resolution from the Hillsborough County Medical Association with reference to changes in service features of Blue Shield contracts. This resolution is being referred to Reference Committee No. 3, Finance and Administration.

As directed by the 1956 House of Delegates, a Blue Shield Liaison Committee has been appointed and is now functioning under the capable leadership of Dr. Henry J. Babers Jr., of Gainesville, Chairman. This is a seventeen man committee comprised of two representatives from each Councilor district and one member at large. The list of the full committee may be found in the committee section of your Journal.

At the request of the American Medical Association and the Chairman of the Poliomyelitis Medical Advisory Committee, Dr. Richard G. Skinner Jr., your Board gave approval of Association sponsorship through the county medical societies of a program designed to have all people in the country under the age of 40 vaccinated against poliomyelitis. You are referred to Dr. Skinner's report in this handbook for further details.

At the January 27 meeting, the Board's attention was directed to a disturbing proposal for industrial group insurance which would require physicians to sign an agreement guaranteeing full-service benefits, with specified exceptions, over which the profession would have no jurisdiction. After careful consideration the Board decided to request the component societies to call this proposal to the attention of their members, urging them to exercise caution before making any definite commitment and to await the action of this House on a resolution to be presented, but which was not drawn in time to be included in the published Handbook. This resolution is being referred to Reference Committee No. 2, Public Policy, and all interested members of the Association are urged to be present to express their views and aid the committee in its deliberations.

As directed by the 1956 House of Delegates, your Board took under advisement the resolution submitted by the Broward County Medical Association on Standard Insurance Forms. Investigation disclosed that this matter had already been worked out by the Health Insurance Council, in cooperation with representatives of the A.M.A. It was found impossible to utilize just one form for all insurance claims, but a minimum of forms has been developed and approved by the A.M.A. and are available to any insurance firm desiring to use them.

At the request of Governor Collins, a list of nominations for State Board of Health appointments was submitted. Also the Governor requested a list of nominations for vacancies which will arise on the State Board of Medical Examiners. As required by the By-Laws, nominations were solicited from the county medical societies and will be submitted to the Governor by the Committee on Legislation and Public Policy.

The 1956 House of Delegates approved a resolution by the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society on study of driver licensing law. This resolution contained a provision that the Florida Medical Association appoint a Medical Advisory Committee to assist

the State of Florida as required in this capacity. This recommendation has been approved by the State Government and a Medical Advisory Committee to the Florida Highway Patrol has been appointed.

Your Board believes that a member who has served the Association and the public the 35 years required by the By-Laws to become eligible for Life Membership merits an expression of appreciation. In view of this a Certificate of Merit has been designed and will be issued to each Life Member of the Association. It is planned that in future years those members of the Association achieving Life Membership status during the current year will be recognized at the annual meeting and a certificate awarded to them at that time. Because the Sarasota County Medical Society on April 9 paid tribute to Dr. Joseph Halton for having practiced in that community 50 years, and because Dr. Halton had a corresponding record of 50 years' membership in the Association, your President was pleased to present the first of these certificates to Dr. Halton at that time. All other current Life Members will receive certificates either in the special ceremony at this meeting, or, in the event they are unable to attend, will be mailed to them as soon as possible following termination of this convention.

Sub-Committee to the Board of Governors on Veterans' Care

Frederick H. Bowen, *Chairman*

During the year 1956, 36,740 authorizations were issued to physicians in the State of Florida for medical care and treatment of eligible veterans. This required an obligation of $362,780.00.

During 1956 a booklet containing the Fee Schedule and agreement between the Florida Medical Association and the Veterans Administration was prepared, and this is being sent to physicians who are performing services for the Veterans Administration. Any physician who wishes a copy of this booklet may obtain one by writing Mr. Ernest R. Gibson at the Jacksonville headquarters of the Florida Medical Association. In the interest of economy, a copy was not sent to all members of the Florida Medical Association.

It was stated during the special called meeting of the House of Delegates in Jacksonville in November that the Fee Schedule with the Veterans Administration was supposed to be renegotiated each year. Your Chairman, in the interest of saving time, did not correct that statement. For the sake of accuracy, however, it should be stated that the agreement with the Veterans Administration and the Fee Schedule are renewed each year. Unless we can present evidence that the cost of medical practice has increased markedly since the time the last Fee Schedule was negotiated, there is not much basis for arguing for a higher Fee Schedule. The cost of medical practice has increased moderately in some of the metropolitan areas of Florida, while in other areas this increase has been slight. This Fee Schedule was renegotiated six or seven times after it was first negotiated in 1946. There have been no major changes in the fees since 1952, and of course the cost of living index has increased only slightly since that time.

The first case of dispute between the Veterans Administration and a member of the Florida Medical Association over fees is now being examined by our Board of Review. The fact that this is the first case in our nine years of operation speaks well for the functioning of the Veterans Administration and the cooperation of our members in the state.

Sub-Committee to Board of Governors on Blue Shield

Russell B. Carson, *Chairman*

Following the 1956 annual meeting of the House of Delegates, the President of the Florida Medical Association followed the directive of the House and appointed a Committee on Blue Shield. This committee, sometimes known as The Committee of Seventeen, under the Chairmanship of Dr. Henry Babers has functioned energetically and enthusiastically, having met jointly with the Board of Directors, sent representatives to each Board Meeting and held several independent meetings. Cooperation has immeasurably improved the understanding of the problems faced by Blue Shield.

In accordance with the resolutions presented by the Active Members of Blue Shield to the Board of Directors at the 1956 annual meeting, an attempt is being made to more fully enlighten the members of the Florida Medical Association of Blue Shield's activities. The Committee of Seventeen has been fully used in this capacity. A News Note from Blue Shield of Florida is being sent to each participating member once per month. The Blue Shield Medical Care Plans Newsletter, prepared by the Blue Shield Commission in Chicago, is also being distributed to the active membership.

On Dec. 7, 1956, the Dependents' Medical Care Act became effective with Blue Shield selected to act as the Fiscal Agent for the State of Florida. This program is now beginning to function. However, the burden of this added activity will require more time for observation before a report can be made.

Under consideration, study, and preparation for final action by the Board of Directors between now and the 1957 Annual Meeting are modifications of the By-Laws to extend the functions of the Active Members; revision of present contracts; presentation to the membership of proposed additional contracts; and a careful observation of the financial status of Blue Shield. A premium rate increase on group contracts was required in October. A rate increase for individual contracts will be required in the near future. The utilization of Blue Shield during 1956 has markedly increased over 1955—i.e.: from 83.9% in 1955 to 88.3% for the twelve months ending December, 1956. This usage of Blue Shield can be controlled only by the participating physician. Otherwise, it must be dealt with by increasing the cost to the subscriber.

Supplement

This supplement to the report of the Board of Governors is in addition to and a part of the original report as printed in the Handbook. It is submitted to include a meeting of the Board in Jacksonville on April 7, 1957.

Your Board, after careful consideration, approved:

1. A resolution disfavoring the participation of any member in a group insurance proposal which would require physicians to sign an agreement guaranteeing full service benefits. This was referred to in the original report as published on page 32 of the Handbook. The resolution is a follows:

Resolution

WHEREAS, the individual member of the medical profession has secured professional, social, economic and political advantages through membership in County, State and National Societies, and

WHEREAS, in this age of centralization, such groups as organized government, organized business and organized labor are continuously endeavoring to take advantage of the medical profession, and

WHEREAS, the individual member of the medposition to exert pressure or influence except through his medical societies, such as the Florida Medical Association, and

WHEREAS, the participation by any members of the profession in service type health insurance plans which have not been investigated and approved by the Florida Medical Association is not in the best interest of the medical profession as a whole or the public,

BE IT THEREFORE RESOLVED, that the Board of Governors of the Florida Medical Association strongly advise the individual member not to participate in any such plan that has not been thoroughly investigated both from the professional and legal viewpoints and approved by the Florida Medical Association.

2. The report of the Chairman of the Committee on Legislation and Public Policy, Dr. H. Phillip Hampton, with regard to bills introduced or anticipated being introduced into the Legislature affecting the practice of medicine. The Board endorsed the recommendations of the Chairman with additional instructions in certain instances. A more detailed report will be presented by Dr. Hampton as a supplement to his report at this session of the House of Delegates. (Approved by Reference Committee No. 4.)

3. An operating budget submitted by Dr. Samuel M. Day, Secretary-Treasurer, for the fiscal year ending March 20, 1958, as amended, in the amount of $169,494.35. A copy of this budget is on file in the Executive Office and will be made available to any member on request.

4. Two nominees for each vacancy on the Blue Shield Board of Directors for presentation to the active members of Blue Shield at its annual meeting on May 6, 1957, at the Hollywood Beach Hotel. A slate from which these nominees were selected was presented to the Board of Governors by the Blue Shield nominating committee, Dr. Clyde O. Anderson, Chairman.

5. Referral without recommendation to Reference Committee No. 2, the proposal of the Committee on Medical Education and Hospitals to the House of Delegates in 1956 and again this year, a per member assessment for contribution to the American Medical Education Foundation fund. Each county medical society was requested to ascertain from its membership its preference in this proposal. As this report is being prepared, we have received replies from 25 county societies. Of these 6 approved an assessment and 19 were opposed. The replies from the county societies are being made available to the reference committee to aid in its deliberations. (See Report of Reference Committee No. 2.)

6. The progress report on the Florida Medical Medical Foundation by Dr. Edward Jelks, President. In my original report, you will find on page 30 reference to the Foundation with a statement that information will be presented to members in the near future. Your attention is directed to the display in the lobby of the hotel. It is hoped that every member will visit this booth and avail himself of the opportunity to learn more about the Foundation.

7. Proposed articles of incorporation and proposed Constitution and By-Laws for the Woman's Auxiliary. The Auxiliary is to be commended for this progressive step.

8. The recommendations of the Committee on Liaison with Medical Schools. (See Report of Reference Committee No. 2.) On pages 22 and 23 of the Handbook, in the report of the Committee on Medical Education and Hospitals, Dr. Walter E. Murphree, Chairman, and on pages 30 and 31 of the original report of the Board of Governors, reference is made to the establishment of a Committee on Liaison with Medical Schools. This Committee held its first meeting in Gainesville on March 31 and arrived at certain recommendations which were approved by the Board on April 7. These recommendations are:

 (1) That the limit of "take home pay" be set for geographic full time faculty members by the Executive Committees and Deans of the medical schools, with the full knowledge of the Medical Schools Liaison Committee, which subject shall be an item on the agenda at its semi-annual meetings.

 (2) That the Medical Schools Liaison Committee shall meet twice yearly to consider any problem that might arise in such liaison.

 (3) That recommendation No. 4 of the Report of the Committee on Medical Education and Hospitals of August 6, 1956 shall read: "That all patients treated in medical school facilities be used for teaching purposes. That all private patients treated by geographic full time faculty members must be referred by a licensed physician."

 (4) That the Board of Governors be requested to ask County Medical Societies where medical schools are located to establish a liaison committee of not more than three members to meet with an equal number to be appointed by the Dean of the Medical School. The purposes of these committees to be essentially the same as the state committee, though on a local level, and to cooperate with the state committee.

10. The actions and correspondence of the Secretary and the Chairman of the Committee on Legislation and Public Policy with reference to bills introduced into the House of Representatives by members of the Florida delegation proposing additional Veterans Administration hospital facilities in Florida, particularly a neuro-psychiatric hospital at Gainesville. You will recall that this same issue was raised several years ago (1954) and that the House of Delegates supported Dr. Herpel in his opposition to these additional facilities. We believe that the efforts of your officers, with the assistance of the Washington Office of the A.M.A., have been effective and that such legislation is not likely to be enacted during the current session. This serves to remind of the ever constant threat of the socialization of medicine through the Veterans administration. Each member of the Association should constantly endeavor to keep his congressmen informed of the medical profession's valid objection to unnecessary expansion of veterans' hospital facilities with its terrific drain on the treasury.

11. The report of the current status of Medicare by Dr. John D. Milton, Chairman, Medicare Mediation Committee. The Association has been advised that the Office for Dependents' Medical Care will ask for an extension of contract prior to the expiration date of July 1, 1957, due to insufficient time having elapsed to acquire adequate information as a basis for renegotiation. The tentative schedule set up is for renegotiation for Florida in April, 1958. It is believed that the delay in negotiations will be advantageous to both the Government and the profession in view of the short time in which the program has been in operation and due to the multitude of problems which are constantly arising and being solved day to day in the early stages of the program.

"Your committee recommends that the Report of the Committee on Necrology, with the supplemental report, by Dr. Alvin L. Stebbins, Chairman, be received and recorded."

Dr. Langley asked that the House stand for a moment of reverent silence in tribute to those who have gone ahead.

Report of Committee on Necrology

Alvin L. Stebbins, *Chairman*

During the last fiscal year our Association lost by death the members whose names are listed below:

Gail E. Chandler, Miami
Leonard H. Conly, Key West
Francis A. Copp, Jacksonville
Leroy B. Elliston, Fort Lauderdale
Frank J. Farley, Dade City
Harry T. Fenn, Mount Dora
Louis J. Garcia, Tampa
Robert B. Harkness, Lake City
Benj. F. Hodsdon, Jacksonville
Harvey J. Howard, Clearwater
Ray W. Hughes, Lake Worth
Frederick C. Keisling, Jacksonville
Prescott LeBreton, St. Petersburg
Samuel D. W. Light, Miami
John W. McClane, Fernandina Beach
John J. McGuire, Pensacola
William D. Nobles, Pensacola
Andrew M. O'Hara, Sneads
John H. Owens, Orange Park
Wm. R. Schnauss, Jacksonville
Robt. D. Sistrunk, Dade City
Rollin D. Thompson, Coral Gables
Leon M. Thurston, St. Petersburg
Russell S. Underwood, Perrine
Clayton D. Washburn, Jacksonville
Charlotte K. Wilkins, North Miami
Arthur G. Williams Sr., Lakewood
Carl A. Williams, Noank, Conn.

When possible, obituaries have appeared in The Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

Supplement

Since the Handbook went to press, the following members have been lost by death:

George E. Beckman, Jacksonville
Guy W. Heath, West Palm Beach
Gordon F. Henry, West Palm Beach
Wm. J. Lancaster, Tampa
Chas. W. Larrabee, Bradenton
Harrison G. Palmer, St. Petersburg
Adelbert F. Schirmer, Orlando
James A. Smith, Sanford
Ralph S. Torbett, Tampa
Theodore M. Trousdale, Sarasota
Benjamin A. Wilkinson, Tallahassee

"It is recommended that the Report of the Committee on Advisory to Woman's Auxiliary, Dr. John P. Ferrell, Chairman, be approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Motion seconded and carried.

Report of Committee on Advisory to Woman's Auxiliary

John P. Ferrell, *Chairman*

The Woman's Auxiliary, under the very capable leadership of Mrs. Scottie J. Wilson, has functioned smoothly and efficiently during the past year. Their membership has grown to over 1800. Our wives continue to take an active part in nurse recruiting, mental health, educational foundation work, civil defense, cancer education, public relations, legislation, and their Today's Health project. An excellent year book was also issued to all members.

With the growth of the Auxiliary, it has become evident that it may be wise for them to incorporate. This is a complicated process, but Mrs. Richard Stover has accepted the task of organizing the necessary rules, charter, and legal advice along these lines, and we hope to be able to present the final plans to the Florida Medical Association at the 1957 meeting for final approval.

"The report of Councilor Districts and Council and the supplemental report, by Dr. Herschel G. Cole, Chairman, is approved.

"I move the adoption of this portion of the report."

Seconded by Dr. W. Dean Steward.

Motion carried.

Report of Council

Herschel G. Cole, *Chairman*

During the annual meeting of the Florida Medical Association the Council was organized. This year only two matters came to the attention of the Council. Fortunately, a turn of events solved them without official action.

The four district meetings were held in Tallahassee, Ocala, Tampa, and West Palm Beach on October 30-31, November 1-2, respectively. All the state officers were present giving an interim report on the affairs of the Association. In addition, Dr John D. Milton attended each meeting explaining in detail the federal law regarding the medical care of military dependents. This was a long, tiresome, and arduous task and the Council wishes to express its deep appreciation to Dr. Milton. Dr. Edward Jelks also deserves and is given special recognition for his unselfish giving of time and effort in explaining the "Indigent Medical Care Program."

Throughout the meetings the subject of medical and surgical care of "Regional Ileitis and Colitis" aroused much interest and discussion particularly in its relationship to the President of the United States. The Council expresses appreciation to all the officers and members of the Association who so liberally gave time and effort in staging the four excellent district meetings.

Deep gratitude is expressed to the officers of the Ladies Auxiliary in providing work shops at each meeting. President, Mrs. Scottie J. Wilson, and President-Elect, Mrs. Perry D. Melvin, graced each meeting with their presence. Compliments are extended to the Vice Presidents, Mrs. A. F. Weekley, Mrs. Lee Rogers Jr., Mrs. Bernard M. Barrett, and Mrs. Willard Fitzgerald, who, with local committees, arranged the "work shops" in their respective districts.

Finally, I wish to express my deep appreciation for the splendid cooperation of the members of the Council; namely, Drs. Alpheus T. Kennedy; Walter J. Baker; Leo M. Wachtel; Charles L. Park Sr.; C. Frank Chunn; Gordon H. McSwain; Ralph M. Overstreet Jr., and Ralph S. Sappenfield.

Supplement

Your council has considered the request and desire of the Santa Rosa County physicians to affiliate themselves with Walton-Okaloosa County Medical Society forming a Tri-County Medical Society to be known as the Walton-Okaloosa-Santa Rosa County Medical Society.

Also, the request of the Suwannee County Medical Society to change their name to the Suwannee-Hamilton-Lafayettee County Medical Society was considered.

It is recommended that both these requests be approved.

"The report of the Committee on Advisory to Selective Service for Physicians and Allied Specialists, and the verbal supplemental report by Dr. J. Rocher Chappell, Chairman, is recommended for approval with an expression of appreciation to Dr. Chappell for his fine work over a period of many years. It is also recommended that this committee be dissolved at the time it legally ceases to function.

"I move the adoption of this portion of the report."

Seconded by Dr. Chas. J. Collins.

Motion carried.

Report of Committee on Advisory to Selective Service for Physicians and Allied Specialists

J. Rocher Chappell, *Chairman*

1. Number of physicians in Priority I who have not served in the armed forces and their current classifications:
 As of 31 December 1956 there are 47 Priority I physicians who have performed no active duty in the armed forces: Five (5) in Class I-D (Reserve); four (4) in Class II-A (essential occupation); thirty-one (31) in Class IV-F (not acceptable for service) and seven (7) in Class V-A (over age). There are twenty (20) Priority I physicians currently serving in the armed forces.
2. Number of physicians who entered military service in 1955 and 1956.
 From records in this headquarters, approximately fifty-four (54) physicians (who are also special registrants) entered service in 1955 and approximately forty-one (41) physicians (who are also special registrants) entered service in 1956. We have no record of the number of physicians entering service who were not required to register under Special Registration No. 1 by reason of being members of reserve components of the armed forces.
3. Number of physicians who have been commissioned but not called to active duty.
 As of December 31, 1956 there are thirty-eight (38) physicians who have received commissions and have not been called to active duty.
4. Total number of physicians who have entered military service since the Doctor's Draft Act was implemented (9 September 1950). From records in this office you are advised that approximately 250 physicians, who are also special registrants, have entered military service from November 1950 to December 31, 1956.

We have not had any meetings of the Committee during the past year. The present work of the Committee consists largely at the present time of writing innumerable letters, answering innumerable telephone calls, and giving interviews either to young physicians who are on imminent call to military service, or to their relatives, friends or patients who feel that they are essential to the community.

Supplement

Advice received from Washington by letter this week states that this committee will cease to exist on June 30, 1957.

"The report of the Committee on Emergency Medical Service by Dr. Rowland E. Wood, Chairman, is approved as printed in the Handbook.

"I move the adoption of this portion of the report."

Seconded by Dr. Fred Mathers.

Motion carried.

Report of Committee on Emergency Medical Service

Rowland E. Wood, *Chairman*

Your committee has been requested by the State Board of Health and the Florida Civil Defense Administration to recommend locations for the storage of five 200 bed improvised hospitals in the State of Florida. These hospitals are loaned to the State of Florida by the Federal Government.

The hospital can be carried in 2,000 cubic square feet. (The largest truck trailer is 10 ft. x 10 ft. x 20 ft. or 2,000 square feet.) The generator (mounted on a trailer) will not go in this but must be brought by some other means. The equipment of the hospital is very much like that of an Army Clearing Company. Not included in the equipment is a microscope and a centrifuge, which the local communities must supply when the hospital goes in operation.

In making these selections there are several things that we believe should be borne in mind:

1. There are no primary target areas in Florida.
2. There are five secondary targets in Florida, viz, Jacksonville, Orlando, Miami, Tampa-St. Petersburg (considered one area) and Tallahassee.
3. Storage of these 200 bed hospitals should not be in the target area, but rather 30-50 miles from the target areas, but rapidly accessible to the areas.
4. Dade county already has a 200 bed improvised hospital which they have made up on their own initiative.
5. We understand that the County Commissioners of Orange County have appropriated money for the purchase of a hospital.
6. Population centers should have the first priority.

With these things in mind our recommendations are as follows:

1. One hospital to service the Jacksonville area.
2. Two hospitals for the Tampa-St. Petersburg area.
3. One hospital plus the already available hospital for the Miami area.
4. One hospital for the Tallahassee-Pensacola area.

The establishment of Emergency Medical Service Committees, or preferably designated as Civil Defense and Disaster Committees in each county medical society is urged. We resubmit the program as contained in the report of this committee last year as a guide for these county level committees:

1. Develop a working plan for the duties and location of work for doctors and allied professions in any type of disaster.
2. Make a survey of available buildings and designation of same to care for patients in the event of a disaster. It is to be recognized that the existing hospitals will not be adequate in the event of a major disaster.
3. Develop a plan for evacuation of surplus casualties to adjacent areas if needed.
4. Contact and cooperate with the Federal Civil Defense Administration and the Red Cross in the development of their plans.
5. Develop a plan to send teams of physicians to other areas if needed.
6. Make a survey of medical supplies available in the area needed in case of a disaster. This should include hospitals, pharmacists, wholesale drug houses, Red Cross and Federal Civil Defense Administration.

7. That the committee cooperate closely with the new Committee on Blood.

It is recommended that the name of this committee be changed to Civil Defense and Disaster Committee and that it be made a regular standing committee of the Florida Medical Association as proposed in the report of the Board of Governors.

"The report of the Blue Shield Liaison Committee and its supplemental report, by Dr. Henry J. Babers Jr., Chairman, is recommended for approval.

"I move the adoption of this portion of the report."

Seconded by Dr. W. Dean Steward.

Motion carried.

Report of Blue Shield Liaison Committee

Henry J. Babers Jr., *Chairman*

This committee made up of 17 representative doctors throughout the state has undertaken to study the relations of the Florida Medical Association and Blue Shield of Florida, Inc. After careful study and discussion, our initial recommendations are these:

1. That Blue Shield is a worthwhile and important phase of our medical practice and that it needs help.
2. That to promote true understanding of the mutual problems, every possible means of informing our membership concerning the activities of Blue Shield should be employed, and that every possible means of informing Blue Shield of the thoughts and problems of our membership should also be employed.
3. That we request Blue Shield to detail to this committee trained professional relations personnel, full time if possible, to give technical help in informing ourselves and the membership.
4. That Blue Shield invite members of this committee to listen in at meetings of the Board of Directors of Blue Shield (this is already being done).
5. That we emphasize the high caliber of men, both professional and lay, on the Blue Shield Board of Directors.
6. That we emphasize the method of selecting the Board of Directors to Blue Shield and emphasize that the voting delegates of the Florida Medical Association are also the acting, voting membership of Blue Shield.
7. That we urge the Association's delegates to know more about Blue Shield and emphasize that it is their right and privilege and obligation to attend the Annual Blue Shield Meeting.
8. That we withhold any discussion of fee schedules and new contracts until the Florida Medical Association Committee on the revised relative value schedule has reported.
9. We suggest that ideas of new and different contracts be seriously studied by Blue Shield itself.
10. We feel that the present service income levels should be kept the same for the present.
11. We recommend that the Blue Shield Board of Directors not make any changes in policy which would affect the contract without prior consultation with this committee and prior approval of this committee.
12. We recommend that the chairman set up some method to pool our information on misdemeanors, complaints, etc. by doctors, by Blue Shield, and by patients. This is to be used for information only and not as a grievance committee.

Supplement

On April 7, 1957, the Advisory Committee to Blue Shield met in Jacksonville, Florida. We voted to make two other recommendations: (1) We recommend to Florida Medical Association that an additional information meeting of the voting members of Blue Shield be considered at an entirely different place than the annual meeting of the Florida Medical Association. Such a meeting should be long enough to allow proper reports and discussion. (2) We request that Florida Medical Association get a report from its relative value schedule committee as soon as possible for use in discussion of other Blue Shield contracts, aside from the Medicare program.

"On the resolution on Blue Shield Service Category, presented by the Hillsborough County Medical Association, the committee believes that this resolution, which was originally written in 1955, presented certain problems the solution to which has been referred to the newly formed Blue Shield Liaison Committee.

"The functions and objectives of the Blue Shield Liaison Committee, as outlined in Dr. Babers' report, indicate that this committee will provide for the requirements of the resolution. Therefore, I move that this resolution not be adopted and not be published in The Journal."

Seconded by Dr. Mallory.

Motion carried.

"The committee recommends that the resolution on Blue Shield Fee Schedule, presented by the Escambia County Medical Society be referred to the Blue Shield Liaison Committee.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Tolle.

Motion carried.

Resolution

Blue Shield Fee Schedule

WHEREAS, The appropriate fees for medical care are not static and must change from time to time to reflect changes in:

1. The general economy,
2. Accepted methods of treatment,
3. Our continuing re-appraisal of the relative value of particular procedures,

BE IT RESOLVED that the Florida Medical Association, through one of its regular committees or through a special committee, review the fee schedule of the Blue Shield Program each two years and recommend any changes which may seem indicated.

Respectfully submitted,

Pascal G. Batson Jr., *Secretary,*
Escambia County Medical Society

"It is also recommended that the Resolution on Increased Blue Shield-Blue Cross benefits, presented by the Broward County Medical Association, be referred to the Blue Shield Liaison Committee.

"I move the adoption of this portion of the report."

Seconded by Dr. Steward.

Motion carried.

Resolution

Blue Shield-Blue Cross Benefits

WHEREAS, it is felt that the only means of maintaining high medical standards in the health insurance field is to keep Blue Cross-Blue Shield a strong competitor.

THEREFORE BE IT RESOLVED THAT the Florida Medical Association approve and endorse the following changes in Florida Blue Cross-Blue Shield:

1. Increase service benefits level to $5,000.00 and $3,600.00 respectively for dependent and non-dependent groups.
2. Increase the fee schedule.
3. Provide major medical coverage working with the Florida Society of Internal Medicine, Florida Academy of General Practice and the Florida Pediatric Society to provide equitable payment.
4. To work with Florida Radiological Society in adopting a plan whereby diagnostic x-rays can be made in a doctor's office and partially paid for by Blue Shield.
5. To make all services customarily rendered by a doctor a Blue Shield benefit and not Blue Cross.
6. To adopt a basic plan that would be acceptable to join with other Blue Cross-Blue Shield plans in obtaining national contracts.
7. To make all changes in service benefits or fee schedules subject to the approval of the active membership of Blue Shield.

Respectfully submitted,
Garland M. Johnson, *Secretary*
Broward County Medical Association

"It is recommended that the resolution on Replacement of Blood by Medicare Patients, presented by the Escambia County Medical Society, be referred to the Committee on Blood, with these recommendations:

"That the Committee on Blood take the initiative in the creation and operation of a group Medicare blood bank account for dependents of the uniformed services, and ask the Service Facilities to take the responsibility for maintaining an adequate supply of blood in this account and issue credits from this account to qualified recipients.

"The reference committee recognizes the fact that community blood bank service charges are not provided for in the Medicare program and recommends that some provision be sought to encourage cooperation between the blood banks and the hospitals for satisfactory billing for this service.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Franklin J. Evans.

Motion carried.

Resolution

Replacement of Blood

WHEREAS, there has not been sufficient clarification as to the Medicare use of blood from blood banks in this State, and there have been no rules for replacement of blood, be it resolved that the FMA through its Delegates try to bring about such agreements as would make it mandatory that Medicare patients replace blood at the blood bank the same as other patients are expected to do.

Resolution adopted by the Escambia County Medical Society on April 9, 1957.

Respectfully submitted,
Pascal G. Batson Jr., *Secretary*
Escambia County Medical Society

"In his address to the First House of Delegates, our President, Dr. Francis H. Langley, made certain recommendations for revising the Constitution and By-Laws and the reorganization of The Journal, which were referred to this committee.

"These recommendations are approved and it is suggested that the details be worked out by the respective committees to be appointed by the new President.

"I move the adoption of this portion of the report."

Seconded by Dr. Patterson.

Motion carried.

(See President's address, page 19 of this issue.)

"Your reference committee wishes to consider the resolution on Medicare, presented by the Broward County Medical Association, and the report of the Medicare Fee Schedule Committee, by Dr. Donald F. Marion, Chairman, jointly.

"First, your reference committee wishes to recommend the highest commendation to Dr. John D. Milton for his unselfish contribution to the members of the Florida Medical Association regarding Medicare.

"Special recognition is also due the Medicare Fee Schedule Committee, Dr. Donald F. Marion, Chairman.

"Your reference committee approves the Broward County Medical Association's resolution in principle, but offers the following resolution in substitute:

"Mr. President, I move the adoption of the substitute resolution."

Seconded by Dr. Steward.

Resolution

Medicare

WHEREAS, the Florida Medical Association desires that the Medicare program be carried out on the American principle of freedom of choice of physician and the freedom of the physician to set his own fees, based, not

on a standardized formula or fixed fee schedule, but on the usual fee charged for such services, and

WHEREAS, we have a firm conviction that better medical care for the dependents will be provided, at lower cost to the taxpayer; the present satisfactory physician-patient relationship continued and incentive for advancement in medical training and practices maintained, if military dependents are cared for on the same basis as other citizens,

BE IT THEREFORE RESOLVED:

1. That the fixed fee schedule contract now in effect NOT be extended beyond the termination date of June 30, 1957.
2. That the Florida Medical Association Board of Governors devise a mechanism to provide dependents with medical care under the provisions authorized by law until a new contract has been consummated.
3. That the Florida Medical Association negotiate a new contract carrying out the principles of this resolution.
4. That the Florida Medical Assoication and each County Medical Society establish a committee to evaluate and recommend the disposition of problems related to the Medicare program.
5. That a copy of this resolution be forwarded to the Secretary and General Manager of the American Medical Association.

Dr. Richard F. Sinnott: "I would like to ask a question about the wording of that resolution. If there is no fee schedule, it is my impression there is no new contract. Perhaps I did not phrase that correctly. I wonder why a contract must be signed at all if we are not going to have a fixed fee schedule?"

Dr. Marr: "We will have to have some form of contract with the Defense Department. We hope the contract will be on the basis of the charge made by the individual physician rather than on the basis of a fixed fee schedule."

Dr. W. Dean Steward: "If I, as an individual physician, am to present my bill, how shall I be obligated by the Florida Medical Association having signed a contract to provide certain services? Why must a new contract be entered into if we are going to submit our bills as individuals according to the usual fees in our community?"

Dr. Marr: "I am of the opinion that it is the wish of the committee that a new contract be devised on the basis of individual fees, which is not a fixed fee schedule."

Dr. James R. Boulware Jr.: "We will have to sign a contract in order to get our money. The Government won't pay us unless we have a contract."

Dr. Herbert L. Bryans: "Since Dr. Milton was chairman of the original committee, I think it would be very wise for us to listen to him."

Dr. John D. Milton: "I was present on that 'infamous' day in November in Jacksonville, and I was the 'infamous' guy who went to Washington. I have no apology for what I was able to do in Washington.

"In principle, I think you have a good resolution. I asked the committee that if they did anything, above all to keep organized medicine in this thing, because if we are not kept in it, we are going to be absolutely divided right down the middle.

"Now you want to know how they handle these things in other states in which they do not have contracts with medicine. First, Indiana. Indiana has a contract with the Defense Department. There are things in this contract that I do not like and I think other individuals would not like either. They do not have any open fixed fee schedule, but they have guaranteed the Defense Department that they will not go over a certain set fee for each item as an average. Do you want to have the plan open and aboveboard, or do you want your association to say under the table, this is what it will be and if they can't come under it, we will send it to Washington for adjustment? Indiana has to pay all of the expenses of operation, including those of the committee for screening the fees.

"Ohio and Rhode Island do not have contracts with the Government. What do they do? The Department of Defense has a contract with a private insurance company. In Ohio it is Mutual of Omaha. The medical association is out; it has nothing to do with it. The government gave Ohio a fee schedule and private industry is carrying out that fee schedule. Someone called Dr. Geo A. Woodehouse yesterday. I understand it is working successfully, but medicine is on the outside.

"Rhode Island is another state and it has only a handful of physicians. Private industry, some insurance company, I don't know which one, is handling Medicare for the Department of Defense. If you have any questions, I will try to answer them."

Dr. Bryans: "What is your opinion as to the procedure we should follow from now on?"

Dr. Milton: "I have no suggestions. The only thing I can say is that I don't want organized medicine written out of this contract. I think we must have a voice. If we don't they will divide and conquer us. I think they have about conquered us anyway."

Dr. Steward: "I want to repeat in essence what I said at the Jacksonville meeting. As long as I can recall, organized medicine has been fighting socialized medicine. When the Government

sets the fee, and pays the money, that is socialized medicine. The present contract expires on June 30, and this is our time to make a change. You will recall the plight of the British physicians; the government obtained an economic squeeze and they couldn't back out. A bill is already being prepared to extend this to the dependents of men who have served 20 years, and there is also a bill up for Federal employees and their dependents. It is still more socialism. When the doctor gets to the place that he is dependent upon this money from the government, he cannot afford to back out because he has to feed his children and pay his insurance premiums.

"As you will remember Lenin said that the socialization of medicine is the keystone of the arch of the socialized state. It is time for the men of Florida to stand up and be counted. If we lead the way, other states will follow. They feel the way we do. We will take care of the dependents of service men, but let's do it the American way—the way outlined by the Chairman of Reference Committee No. 3, who, with his committee members, has done such an excellent job in preparing this resolution."

Dr. Burns A. Dobbins Jr.: "I would like to correct a statement that Dr. Milton made. He is not an 'infamous' person; there is no infamous person, there is only an infamous principle. He should be famous. He has done a good job in negotiating this fee schedule. However, what applies in one section of the State, may not be right in another section. There are vast differences in this state. It is the principle involved in which we are mainly interested and now is the time to assert ourselves. We will care for these patients, we want to care for them, but we want to do it the way medicine has always been practiced in the United States. I admit that there will be some problems involved, it will take a great deal of cooperation and it will take some supervision of those who do not wish to conform. I want to thank the reference committee for their work and commend them for an excellent resolution."

Dr. Herschel G. Cole: "I speak to you as a delegate and also as chairman of the committee of the Florida Orthopedic Society, which has instructed me to give you certain information. I think Dr. Milton should be commended for his tireless efforts and we should also commend the committee for its work on this problem. Yesterday afternoon, I spent a half-hour on the telephone talking to the President of the Indiana State Medical Association. He was very frank about their operation. They have a contract; they do not have a fee schedule. The individual physician sends his bill directly to the medical association, they review it. I believe there is a limit of $300 per case. If there is a disagreement, they try to get the doctor to reduce his fee. Indiana does not have a schedule of fees for another reason. If you are familiar with the geography of the state, you know that the southern part is economically very poor. The northern section is highly industrialized and entirely different. That is the reason they do not have a fee schedule.

"There are many of us here that did not approve the hurry up method that followed the adoption of this law by Congress. Several years ago when we fought socialized medicine so bitterly, we just won an armistice, not a victory. Since that time, the militant socialists have regrouped themselves and those of you who have engaged in military activity will recognize the tactics of infiltrate, divide and conquer. There is a bill to include postal employees, social workers, and it will go on and on. It is like termites getting into your house, and eating and eating, until it falls down. I don't believe we can afford to concede and concede and retrench. Your best defense is attack, which should be done with cool reasoning and good judgment and I believe your committee has tried to do that.

"I want to present to you the recommendations of the Florida Orthopedic Society. We are definitely opposed to extension of the time. We believe the contract should be for one year only. We are definitely opposed to any other group deriving the benefits of this system. That is my personal opinion and I gave you the official opinion of the Florida Orthopedic Society. As I recall, the resolution stated the contract would not be extended. I would like to offer an amendment to the resolution to include in proper phraseology that no further groups shall receive the benefits under this act and under our contract."

Seconded by Dr. Frank L. Fort.

Dr. Steward: "I don't see where we need an amendment as long as we are renegotiating the contract each year. No one else can be put in under that contract."

Dr. Milton: "I would like to reiterate what Dr. Steward has said. It would take a law passed by Congress to put anyone else under this contract. I think if you adopt this amendment, you will weaken a strong resolution."

The Chair called for a voice vote and the amendment was not carried.

Dr. Ashbel C. Williams: "I have heard all the arguments here and while I agree with your feelings, I think we have some precedent as to how well physicians in any large medical association will come through on a matter of this kind. One example is the poor response we get from you on the American Medical Education Foundation. We have been asked to support it by giving $100 a year each, and I think we got $20,000 out of the whole state. Blue Shield could tell you how doctors cooperate or fail to cooperate. I personally believe Dr. Milton did a marvelous job in the contract he negotiated. There are many aspects that were not considered due to lack of time. I think they could be renegotiated and ironed out. In a state where there are as many military dependents as there are in Florida, as was indicated Sunday when we had a representative from the Surgeon General's office tell us that there were only two states in the country that had more military personnel than Florida, that it is extremely important to the Government, not like in Ohio or Indiana where they have only a few, that the Government see that something is set up that is feasible. I don't advocate socialized medicine in any shape or form. If any question comes up of including postal employees, or others, I would fight it tooth and nail. However, I think we should be in favor of supporting, not killing, something that has been started off in such a fair manner to physicians. I would be in favor of renegotiating this contract at the earliest possible time."

Dr. Patterson: "After all this discussion, I wonder if it would not be well for Dr. Marr to read again the recommendations of his committee."

Dr. Langley: "Do you wish to have the resolution read again?"

Many delegates replied in the affirmative.

Dr. Marr re-read the resolution.

Dr. Franklin J. Evans: "While the resolution is fresh in your memories, I move the previous motion."

Seconded by Dr. Sackett.

Motion carried.

Dr. Marr: "I move the adoption of the entire report of Reference Committee No. 3."

Seconded by Dr. Sias.

Motion carried.

The other members of this reference committee were Drs. Francis T. Holland, of Leon-Gadsden-Liberty-Wakulla-Jefferson, Donald W. Smith, of Dade, James R. Boulware Jr., of Polk, and Sidney Stillman of Duval.

The Chair recognized Dr. W. Dean Steward on a point of personal privilege.

Dr. Steward: "It is very important that every member of this House of Delegates go back and acquaint the members of his county medical society with the action of this House. We will need the unanimous support of the medical profession in Florida if we are going to stand against government medicine. I urge you to go back to your county societies and tell them the why's and wherefore's of this vote."

Report of Reference Committee No. 4

The Chair called for the report of Reference Committee No. 4, Legislation and Miscellaneous, Dr. L. Washington Dowlen, Chairman.

Dr. Dowlen: "Your committee approves the report of the Committee on Legislation and Public Policy and recommends that this committee, every county society and Mr. Harold Parham be commended for their part in helping with the bill on naturopathy.

"The Committee observed that the State Department of Welfare's Indigent Hospitalization Program will not be continued as such after July 1, 1957.

"The committee recommends the approval of that portion of the supplemental report presented by the Committee on Legislation and Public Policy approving the action of the committee to support a state appropriation for $4,000,000 for the Hospital Service for the Indigent Program for the biennium 1957-59, on a state-county matching formula.

"Your committee recommends the approval of that portion of the supplementary report which recommends active support of the Jenkins-Keogh bill now being considered by Congress.

"Your committee recommends the approval of the action taken by the Committee on Legislation and Public Policy and approved by the FMA Board of Governors on the various health bills being considered by the present session of the state legislature.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Patterson.

Motion carried.

Report of Committee on Legislation and Public Policy

H. Phillip Hampton, *Chairman*

Your Committee has been active constantly during the past year in an attempt to assume the responsibilities placed upon us to represent the Association in promoting, securing and maintaining legislation in the best interest of public health and scientific medicine.

National Legislation

Close attention was given to our national legislative program and requests from the A.M.A. Committee on Legislation and the A.M.A. Washington Office to assist with specific legislation were complied with. We were very fortunate again this year to have among us in Florida, Reuben B. Chrisman Jr., M.D., of Miami, a member of the A.M.A. Committee on Legislation, whose broad knowledge of medical legislation and generous assistance has been of great value.

Our key contact physicians in Florida for national legislation should also be complimented for their prompt action when called upon for assistance.

State Legislation

Your Committee studied all the proposed legislation received from the county medical societies, referred by the Association's President, requested by the House of Delegates, referred by allied organizations and state officials.

This proposed legislation was presented with recommendations to the Pre-Legislative Joint Meeting of the F.M.A. Board of Governors, members of the House of Delegates, Bureau of Public Relations and Committee on Legislation and Public Policy held on May 14, 1956 in Miami. The proposed legislation was discussed at this meeting and a definite program was adopted.

The program will be presented to the Legislative Committee and officers of each county medical society urging them to inform the members of the society and explain the program to their legislators prior to the 1957 Session of the Florida Legislature.

Many meetings and conferences have been held, personal contacts made, communications written and numerous other activities which would be too voluminous to include in this report. Special note should be made that the President of the Senate and Speaker of the House have been contacted by representatives of the Association urging them to appoint legislators to the Public Health Committee of the Senate and the House who will assure that fair consideration is given to the Association's legislation in hearings before these committees.

An office will be maintained at Tallahassee during the entire 1957 Session of the Legislature by Harold Parham, of the Association's executive office, and an attorney retained by the Association. This office is for the convenience of the legislators and others who may seek information on problems concerning medicine, health and education as they effect legislation for the protection and benefit of Florida's citizens.

Again your Committee would like to emphasize that the success or failure of our Association's state legislative program depends primarily upon work done at the local level by an informed membership in developing better relations with legislators at home prior to the legislative session.

Today's Health, the American Medical Association's health magazine for lay readers, is being sent again this year to Florida's U. S. Senators and representatives, the Governor and members of his Cabinet and state legislators.

On behalf of the Committee, I desire to express appreciation for the assistance rendered by the President, Secretary, and other state association officers, Supervisor of the Association's Bureau of Public Relations, and other members of the executive staff, members of the legislative committees of the county medical societies and the many individual members who have responded when called on for assistance.

"The report of the Committee on Mental Health, Dr. Sullivan G. Bedell, Chairman, is approved with commendation for the Committee.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Collins.

Motion carried.

Report of Committee on Mental Health

Sullivan G. Bedell, *Chairman*

Your Committee at its meeting in May 1956, set a goal of placing the physicians of Florida in a position of leadership in regard to mental health problems within our state and considered long range problems for committee action.

A comprehensive list of these problems to be considered follows:

I. Mental Health Topics Concerning Primarily the Profession
 1. Dissemination of information regarding mental health topics among the profession.
 2. The need for prevention of the sale of bromides without a prescription.
 3. Licensure versus certification of psychologists.
 4. The use of hypnosis in general practice.
 5. The use of tranquilizers in general practice.

II. Mental Health Topics Concerning the Public As Well As the Profession
 1. Research in mental health.
 2. Training in mental health.
 3. The care of psychotic and emotionally disturbed children.
 4. The care of psychotic and emotionally disturbed old people.
 5. Provision of state funds to reimburse local communities for the care of committed patients awaiting transfer to state institutions.
 6. Policies regarding state institutions.
 7. Policies regarding mental health clinics.
 8. Policies regarding psychiatric facilities in prisons and training schools.
 9. Policies regarding a counseling program in public schools.
 10. Problems relating to narcotic addiction.
 11. Problems relative to sexual psychopathy.
 12. Policies regarding the state alcoholic rehabilitation program.

Early in October, a planning and coordination meeting was held by your Committee with legislators and heads of mental health groups and agencies to promote an understanding and united front with medical leadership in this field.

Your Committee sponsored a statewide conference on mental health in late October 1956, at Jacksonville. The State Board of Health and the Florida Mental Health Association were co-sponsors. Invitations were extended to each county medical society and to leaders of various organizations and agencies interested in mental health in Florida. Sixty people attended. Mental health needs likely to be considered at the next session of the Florida Legislature were presented and discussed. The presentation of positive recommendations which developed at the planning and coordinating meeting proved to be most beneficial.

Your Chairman attended the public hearings of the Interim Legislative Committee on Mental Health of the Florida State Legislature in January 1957 and presented the following report and recommendations:

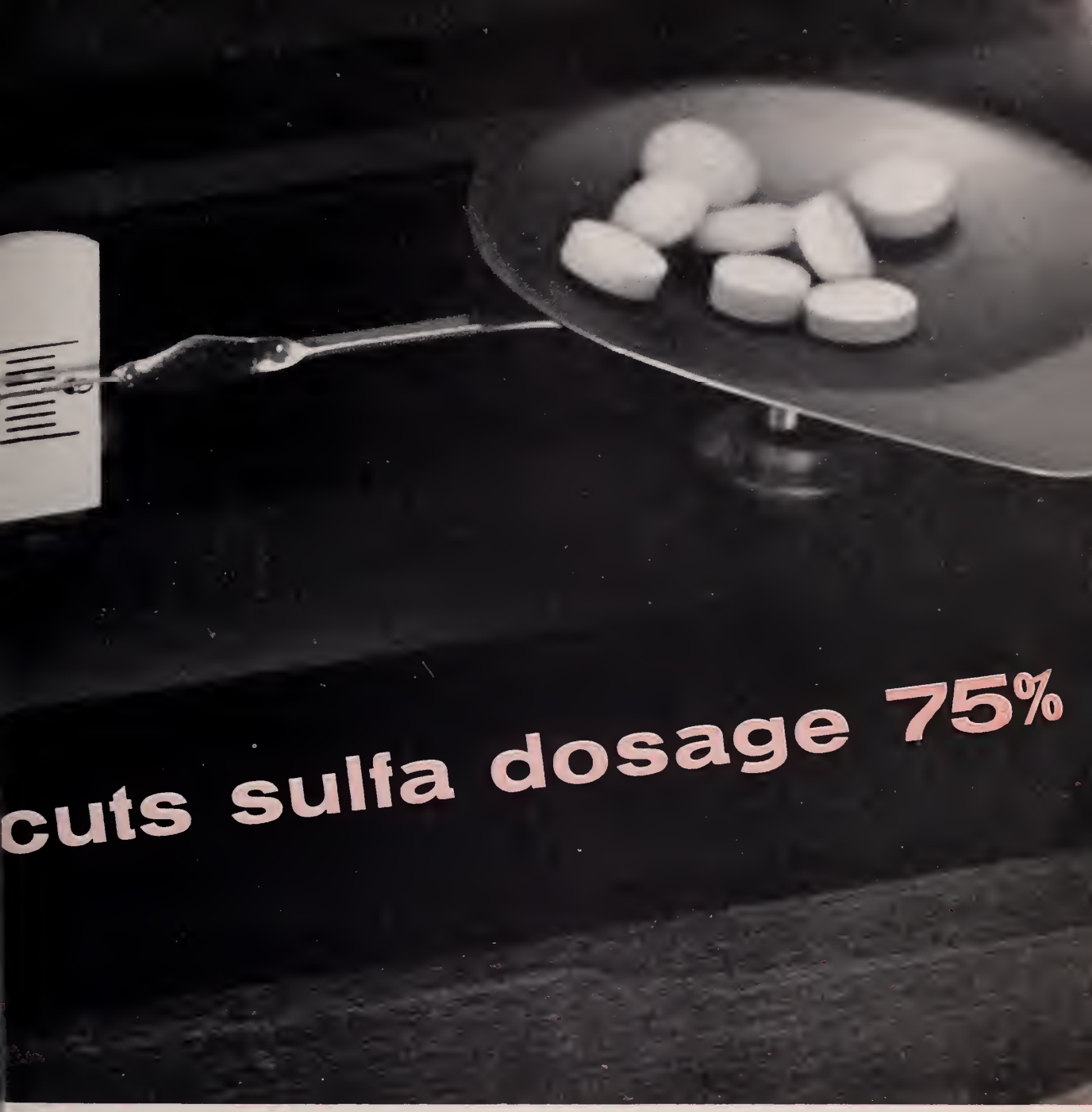
The Mental Health Committee of the Florida Medical Association respectfully recommends that the Joint



antibacterial

effectiveness for 24 hours

on a single (1 Gm.) dose



ıEX Sulfamethoxypyridazine is a completely new, long-act- single sulfonamide with clinical advantages hitherto un- ıaled in sulfa therapy—

W DOSAGE[1] —only 2 tablets per day.

PID ABSORPTION[1] — therapeutic blood levels within hour, blood concentration peaks within 2 hours.

OLONGED ACTION[1] — 10 mg. per cent blood levels that sist over 24 hours on a maintenance dose of 1 Gm.

OAD-RANGE EFFECTIVENESS — particularly efficient rinary tract infections due to sulfonamide-sensitive organ- s, including E. coli, Aerobacter aerogenes, paracolon bacilli, ptococci, staphylococci, Gram-negative rods, diphtheroids Gram-positive cocci.

EATER SAFETY — high solubility, slow excretion and low age help avoid crystalluria. No increase in dosage is recommended; the usual precautions regarding sulfonamides should be observed.

CONVENIENCE — the low maintenance dosage of 1 Gm. (2 tablets) per day for the average adult offers optimum convenience and acceptance to patients.

Each quarter-scored tablet contains: sulfamethoxypyridazine ... 0.5 Gm. (7½ grains).

1. Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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Interim Legislative Committee favorably consider legislation to accomplish the following:

1. Promotion of mental health clinics and provision for mental health workers in county health units through the Bureau of Mental Health of the State Board of Health.
2. Funds for scholarships and training in mental health professions and for a sizeable increase in funds for mental health research.
3. Funds for improvements at Chattahoochee and Arcadia, for promotion of the work at S.E. Florida Hospital, and for earliest possible completion of the N.E. Florida Hospital.
4. Arcadia to be made an institution separate from the one at Chattahoochee.
5. (a). Promotion of the work at the Florida Farm Colony.
 (b). Establishment of a new institution for the mentally retarded.
6. Continuation of the work of the Florida State Alcoholic Rehabilitation Program.
7. A program of educational and vocational guidance in the public schools.
8. Psychiatric services at the State Penal and Corrective Institutions.
9. In-patient care for psychotic and emotionally disturbed children in connection with the new state hospitals. $720,000 for unit at S.E. State Hospital—48 beds.
10. Establishment of a position for a psychiatric administrator as Coordinator of State Mental Institutions.

The Interim Legislative Committee requested the official position of the FMA on these recommendations, therefore they were presented to the FMA Committee on Legislation and Public Policy and FMA Board of Governors. All recommendations were approved by both groups in January 1957.

Your Chairman attended the third annual meeting of the AMA Council on Mental Health in Chicago in November 1956, where discussion groups considered the following topics:

1. Use of Hypnosis in Medical Practice.
2. Alcoholic Patient as a Medical and Hospital Management Problem.
3. Benefits and Problems Encountered by General Practitioners with Use of Newer Tranquilizing Drugs for Patients with Emotional Illness.
4. In-patient Psychiatric Care of Children.

It is increasingly important for the Mental Health Committee of the Florida Medical Association to have close ties with mental health committees of the county medical societies so that the local committees can participate in working out solutions to mental health problems and can interpret to the county medical societies, to their legislators, and to their committees the stand taken by the Florida Medical Association.

Your Committee recommends that special attention be given next year to the following:

1. Promotion of active mental health committees in each county medical society.
2. Care of the sexual psychopath.
3. Care of the psychotic aged.
4. Care of the narcotic addict.
5. Prohibition of the sale of bromides without prescription.
6. Work shop conferences on items 2-5 and other topics, urging participation from the component county medical societies.
7. A Fall meeting, attempting to bring together representatives from all groups interested in mental health.

Your Committee desires to express appreciation for the assistance given by the officers and individual members of the Association who have responded so well when called upon to assist with the mental health program.

"The report of the Committee on State Controlled Medical Institutions, by Dr. William D. Rogers, Chairman, is approved as printed in the Handbook.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Kennedy.

Motion carried.

Report of Committee on State Controlled Medical Institutions

William D. Rogers, *Chairman*

As Chairman of the Committee on State Controlled Medical Institutions, I take pleasure in submitting the following report, covering the Florida Farm Colony at Gainesville, the Alcoholic Rehabilitation Center at Avon Park, the Florida State Hospital at Chattahoochee and the Florida State Hospital at Arcadia, and the new South Florida State Hospital presently under construction.

The Florida Farm Colony

The Florida Farm Colony, which cares for mentally retarded and epileptic patients, has made a great deal of real progress during the past year. There has been further expansion of the physical plant in addition to the professional staff. The Legislature of 1955 provided $2,250,000 for improvements and new construction and this program is well under way. There have recently been completed 12 additional cottages, housing 36 patients each. Also under construction is a nursery and infirmary building for Negroes, which will house 96 patients, and an addition to the infirmary for white patients of 40 beds. When the present construction program is complete the institution will have a capacity for approximately 2,000 children in their current program.

In addition to patient facilities, new construction includes an Administration Building, Chapel, swimming pool, occupational therapy building, and additions to the food service department, as well as quarters for employees.

At present there are 581 employees on the payroll, which amounts to $105,000 monthly. This institution has recently added another physician to its staff, which gives a total of three physicians. There has been an increase in the number of registered nurses, and in the laboratory staff providing three full-time technicians, and at present there are two full time dentists. A school principal has been added during the past year and several additional teachers with a present faculty of 17. Three full time occupational therapists have been added during the past year and additional teachers in the program for trainable children.

There has been considerable improvement in medical facilities in the institution as they now have trained personnel for electroencephalographic and x-ray work. A medical record system has been set up which is approved by the American Medical Association. They have also developed a cottage assignment committee for new patients, and have established routine hospital staff meetings between the professional staff and other groups, discussing improvements in the care of patients. They have also established an identification system of patients, and have added pre-employment physical examinations for all new employees. They had a paper presented at the Antibiotic Symposium and an exhibit presented at the Southern Medical Association and the American Medical Association, have received a research grant from the Atomic Energy Commission in conjunction with the University of Florida Biochemistry Department, have developed a training program for employees, and have shown much progress in their basic research, especially in the mongoloid patients.

The staff has had eight papers published during the year, which resulted from research at the Florida Farm

Colony, and have already established good working relations with the Medical School of the University of Florida.

I might add that in view of the present size of this institution and their long list of patients awaiting admission, plans are under way to locate and construct a new institution for mentally retarded and epileptic children in the southern part of the state.

The Florida Alcoholic Rehabilitation Program

The Florida Alcoholic Rehabilitation Program is a new service afforded the alcoholic patients of our state, and during the past year this program has continued to develop its services along the three main lines of treatment, education and study.

Treatment is the principal service offered by the Program through four outpatient clinics located in Pensacola, Jacksonville, Tampa and Miami, and through the 50 bed Alcoholic Rehabilitation Center located in Avon Park. Dr. Lorant Forizs continues as Clinical Director and Mrs. Dorothy M. Johnson as Supervisor of Psychiatric Social Work of the program, directing all treatment services. Each of the clinics is headed by a senior physician, who is a psychiatrist. They are as follows: Dr. C. Brooks Henderson, Jacksonville Clinic; Dr. Louis Rogel, Miami Clinic, Dr. Roger Sherman, Pensacola Clinic, and Dr. A. Carl Herman, Tampa Clinic. Since the opening of the clinics in 1955 over 900 patients have been admitted for outpatient treatment.

Each clinic is staffed by full time psychiatric social workers, part time internists and psychologists and full time clerical personnel. The various professions and disciplines compose clinic teams which are regarded as necessary in the diagnosis and treatment of alcoholism.

The new Alcoholic Rehabilitation Center is planned around the concept of intensive treatment of voluntary patients through a "therapeutic community" and group psychotherapy in varied forms is used extensively. The facility has the following multiple functions:

1. Housing the state headquarters for the Program.
2. Housing an outpatient clinic for a 17 county area of South Central Florida.
3. Providing an admissions unit for short-term, intensive, medical care of acute conditions.
4. Providing longer term care for intensive psychotherapy as a part of the rehabilitation of patients.

The new Rehabilitation Center admitted its first patients December 3. Its senior physician is Dr. James A. Mosco, who was appointed at the end of December.

The educational work of the Alcoholic Program, carried out on a state-wide basis, is engaged in the following activities:

1. The dissemination of information through printed materials, films, radio and televised programs, public addresses, newspaper stories, and magazine articles.
2. Sponsoring, planning, and providing specialized inservice training for related professional groups.
3. Coordinating any activities and plans for Public School work with the general health education program as it is now directed by Mr. Zollie Maynard, Consultant in Health, Physical Education and Recreation of the State Board of Education.

Educational activities of the Program are limited to the subject of alcoholism and are directed by Statute to the following groups: the general public, chronic alcoholics or professional persons who care for or may be engaged in the care and treatment of alcoholics. The state-wide mailing list of the Program now has over 9,000 names and addresses of residents who have requested the Program's printed material.

During the initial period of planning and developing services, study and research have not been planned. It is expected that clinical studies will take an important place in the work of the Program after case loads have stabilized.

Florida State Hospitals

The functions of the Florida State Hospital at Chattahoochee and the Florida State Hospital at Arcadia will be considered together, since the institution at Arcadia is presently a branch of the hospital at Chattahoochee.

At the present time, there are 6,606 patients confined in the State Hospital at Chattahoochee and 1,650 patients in the institution at Arcadia. At the close of the last fiscal year, June 30, 1956, a total of 2,578 patients had been admitted during the year; separations from both hospitals during that period of time numbered 2,535. This extremely good record, we feel, was the result of better housing and treatment facilities that had been provided previously, as well as additional staff and the aid of the tranquilizing drugs. With the rapid growth in state population, we are anticipating that the admissions to both hospitals during the coming year will possibly number 3,000.

During the past year many improvements have been accomplished in hospital facilities. Two new buildings have been opened for the care of patients at Chattahoochee, one for aged patients and one for receiving and intensive treatment. At Arcadia five 100 bed continued treatment buildings have been opened.

The present program at Chattahoochee is not for an increase in hospital population but to replace some of the very old and dilapidated buildings now in use.

The psychiatric staffs of both hospitals have been increased and at Chattahoochee the social service department has developed considerably during this period. In the present budget additional social workers have been requested. At the present time the employees at the Florida State Hospital at Chattahoochee number 1,793, and the number at Arcadia is 496. This gives a patient-employee ratio of some 3.7, which is slightly higher than the national average of 3.6 for state mental institutions.

In budget recommendations for the next biennium, additional facilities have been requested for the hospital at Arcadia, including a medical and surgical unit, a receiving and intensive treatment building for women patients, chapel, warehouse, administration building, and expansion of utilities. At Chattahoochee we are requesting one continued treatment building to replace an existing building, which is beyond repair, and additional utilities.

It has also been recommended that the Florida State Hospital at Arcadia be established as a separate hospital and not a branch of the Florida State Hospital at Chattahoochee, due to the increased size of the branch hospital and the great distance between the two institutions.

New South Florida State Hospital

The new South Florida State Hospital, located in Broward County, planned to begin receiving patients about March 1, 1957. This institution is under the direction of Dr. Arnold H. Eichert. This institution will have a capacity of slightly less than 500 patients, however, the second phase of construction will begin soon, increasing the capacity to some 1,300 beds. The staff of this hospital is being organized at present.

New Northeast Florida State Hospital

The 1955 Legislature appropriated $4,200,000 for the construction of a new mental hospital in Northeast Florida, which was located in Baker County some twenty-five miles from Jacksonville. Plans are developing satisfactorily for this new institution and it is hoped that bids for construction will be taken in the late spring.

The Legislature is being asked for $6,500,000 more to complete the second phase of construction of this institution.

These two new state mental hospitals will afford much needed relief in the increasing demands made on the mental hospitals and will also provide facilities near the heavily populated areas.

"The report of the Poliomyelitis Medical Advisory Committee, Dr. Richard G. Skinner Jr., Chairman, was approved with the following

amendment, that a paragraph be added to read:

'The Poliomyelitis Medical Advisory Committee recommends to the House of Delegates that they officially go on record as requesting that the Congress of the United States not renew the poliomyelitis vaccine act which expires June 30, 1957.'

"The Reference Committee would also like the House of Delegates to go on record as not approving the use of state funds for the purchase of polio vaccine for other than indigent persons as outlined in the presently proposed budget of the State Board of Health for the biennium 1957-59."

"Mr. President, I move the adoption of this portion of the report as amended."

Seconded and carried.

Report of Poliomyelitis Medical Advisory Committee

Richard G. Skinner Jr., *Chairman*

In the light of the national stimulus from the American Medical Association to increase the number of people vaccinated against polio, President Langley requested that our committee set up a program to carry out this responsibility.

The principles of the program were approved by the Board of Governors on January 27 and the actual details were worked out in succeeding weeks.

The President of each county medical society was notified as to the purpose of the program and the possible ways in which it could be implemented. One member of each medical society was provided with rather complete material in kit form to set up the program in his individual county medical society. It is anticipated that statewide publicity through all possible means of communication will be carried out and it is the hope of this committee that every doctor's office will become an immunization center.

Since the program is merely in its inception, the results of it are not available, nor the extent of its success. We hope that this committee will be able to say next year that at least 95 per cent of the people of the State of Florida have been vaccinated against polio.

The chairman wishes to express appreciation to the members of his committee for their invaluable assistance, Drs. Frank L. Fort, John H. Cordes, George S. Palmer and Edward W. Cullipher.

The Poliomyelitis Medical Advisory Committee recommends to the House of Delegates that they officially go on record as requesting that the Congress of the United States not renew the poliomyelitis vaccine act which expires June 30, 1957.

"The resolution on changes in State Welfare Law, submitted by Escambia County Medical Society, is approved as printed in the handbook.

"I move the adoption of this portion of the report."

Seconded by Dr. Kennedy.

Motion carried.

Resolution

Changes in State Welfare Law

It has become increasingly evident to physicians participating in the Indigent Hospitalization Program that many present recipients of welfare aid should not, because of the financial status of their children, be eligible for this program. The law is inconsistent in that it provides for relative responsibility in the Aid to the Disabled Program, but not in the Aid to the Blind and Old Age Assistance. At the present time any individual over 65 years of age with homestead property assessed at $5000 or less and with other resources of less than $600 (if single or $900 if married) is eligible for Old Age Assistance. Legally no consideration is given to the ability of the relatives to support these aged persons, although in practice, the Department of Public Welfare does make every effort possible to locate and interview the applicants' children to determine their willingness to support their parents. A statement regarding "unwillingness" or inability to support them is sufficient to qualify the oldster for state aid. This defect in the State Welfare Law has allowed to be placed on the welfare rolls many individuals who could be adequately taken care of by their children if their welfare income were withdrawn. This has placed an unnecessary burden upon the taxpayers of the State of Florida and has also reduced the quantity of assistance available to those individuals who truly need State Assistance.

BE IT THEREFORE RESOLVED that the Escambia County Medical Society recommend to the Florida Medical Association the active participation of its membership in a concerted effort to effect the necessary changes in the State Welfare Law and that the State Department of Public Welfare be advised of our willingness to share in this effort.

Respectfully submitted,

Pascal G. Batson Jr., *Secretary,*
Escambia County Medical Society

"The resolution on Workman's Compensation Fee Schedule, submitted by the Escambia County Medical Society is approved with the recommendation that it be referred to the appropriate committee at the discretion of the Board of Governors.

"I move the adoption of this portion of the report."

Seconded and carried.

Resolution

Workman's Compensation Fee Schedule

WHEREAS, The appropriate fees for medical care are not static and must change from time to time to reflect changes in:

1. The general economy,
2. Accepted methods of treatment,
3. Our continuing re-appraisal of the relative value of particular procedures,

BE IT RESOLVED that the Florida Medical Association, through one of its regular committees or through a special committee, review the Workman's Compensation Fee Schedule each two years and recommend any changes which may seem indicated.

Respectfully submitted,

Pascal G. Batson Jr., *Secretary,*
Escambia County Medical Society

"The resolution on Indigent Service, submitted by the Orange County Medical Society, is approved with the following amendment: In item 2, under certification of professional opinion, change the words 'to the best of my knowledge and belief' to read 'so far as I know.' It is recom-

mended that the Advisory Committee to the State Board of Health for Indigent Hospitalization make the requested change.

"Mr. President, I move the adoption of this portion of the report as amended."

Seconded by Dr. Steward.

Motion carried.

Resolution

Indigent Service

WHEREAS, Many patients are medically indigent although not dependent on Welfare, and

WHEREAS, Many patients, although medically indigent, have children that are financially able to assist them, and

WHEREAS, Although many patients are medically indigent regarding hospitalization, they are able to pay partially for medical service,

BE IT THEREFORE RESOLVED, that the Florida Medical Association recommend:

1. That family responsibility be included in all Welfare and Medically indigent cases.

2. In the Application and Authorization Hospital Service for the Indigent (Form PA-66, Florida State Welfare Department or Form "A" Florida State Board of Health), change the first section from:

This is to certify that I am unable to pay for medical treatment or the cost of hospitalization hereby requested.

To: This is to certify that I am unable to pay the cost of hospitalization hereby requested.

Change the 2nd section from:

This is to certify it is my professional opinion: (1) The patient is acutely ill or injured: (2) Hospitalization is essential to the treatment of this patient, and (3) This patient can be helped markedly by treatment in a hospital. As far as I know this patient is unable to pay for medical treatment or for the cost of hospitalization.

Respectively submitted,
W. Ansell Derrick, *Secretary*
Orange County Medical Society

"The resolution on Abolition of Tuberculosis Board, submitted by the Orange County Medical Society, is recommended for referral to the Committee on Tuberculosis and Public Health.

"I move that this portion of the report be adopted."

Seconded and carried.

Resolution

Tuberculosis Board

WHEREAS, the Florida Tuberculosis Hospital System, under the present management of the Tuberculosis Board of five members, appointed by the Governor for staggered terms, has achieved the lowest tuberculosis morbidity and mortality rate of any state in the South Eastern United States as seen by U.S. Public Health spot maps and statistics.

WHEREAS, the House Bill 578 and Senate Bill 406 proposing the abolition of this nonpolitical board would place the Tuberculosis Hospital System under administration of the Governor and his cabinet, subject to recurrent change with each new head of our state government, and would subject the program to political effects detrimental to the health and welfare of the people of Florida.

RESOLVED, that the Orange County Medical Society recommend that the Florida Medical Society go on record as opposing the passage of House Bill 578 and the similar Senate Bill 406 which would abolish the present State Tuberculosis Board and place the operation of the Tuberculosis Hospital System under direction of the Governor and his Cabinet.

Respectively submitted,
W. Ansell Derrick, *Secretary*
Orange County Medical Society

"The resolution on Minimum Standards for Motor Vehicle Licensing, presented by the Pinellas County Medical Society, is approved with the following amendments: In the 3rd paragraph the words 'on today's crowded highways' are deleted.

"Because the A.M.A. has been working on this matter for 1½ years, we recommend that this be sent to the Secretary of the A.M.A. for information and that a copy be sent to the F.M.A. Medical Advisory Committee to the Florida Department of Public Safety.

"Mr. President, I move the adoption of this portion of the report as amended."

Seconded by Dr. H. Phillip Hampton.

Motion carried.

Resolution

Minimum Standards for Motor Vehicle Licensing

WHEREAS, the operation of a motor vehicle on the public highways is a grave responsibility and not an inherent right of the free citizen because life and public property are frequently in peril; and

WHEREAS, the operation of a motor vehicle safely on our crowded highways requires certain physicial, mental, and psychological proficiencies; and

WHEREAS, there are no recognized minimum physical, mental, and psychological standards by which drivers may be measured in determining fitness for driving safely.

NOW, THEREFORE, BE IT RESOLVED that the Pinellas County Medical Society urge the American Medical Association, through the Florida Medical Association, to lead the way with the cooperation of the National Safety Council and American Liability Insurance Underwriters in establishing minimum standards of physical, mental, and psychological ability for the safe operation of motor vehicles, and that these minimum standards be presented to the Joint Governors' Conference in the development of uniform driver regulation to require acceptance of the responsibilities dependent upon the assumption of driver privileges.

Respectfully submitted,
Whitman C. McConnell, *Secretary*
Pinellas County Medical Society

"The resolution on the Annual Dinner, submitted by the Escambia County Medical Society is disapproved with the recommendation that it be passed on to the Board of Governors so that they may be advised of the feelings of the Escambia County Medical Society on this matter.

"Mr. President, I move this portion of the report not be approved."

Motion seconded.

Dr. Herbert L. Bryans: "The intent of that resolution was more or less to have an expression of this group whether they wish to abolish the

Annual Dinner. This information is needed as a guide to the Board of Governors. They want an expression from this group."

Dr. Eugene G. Peek Jr.: "I think we certainly should have an Annual Dinner. I think it is high time we got back to recognizing our Past Presidents, members of the Board and the various committees, those men who serve during the entire year so unselfishly. They should be presented to the entire Florida Medical Association and recognized at the Annual Dinner."

Dr. Turner Z. Cason: "I am seriously and heartily in favor of the dinner. The cocktail party is fine, but it should not precede the dinner. It should be held the night before. The dinner should be held on Tuesday night. Then, a little more thought should be given to selecting a speaker who will say something that is worthwhile to all of us."

Dr. William H. Grace: "I would like to endorse what Dr. Cason said."

Dr. Samuel M. Day: "I would like to express appreciation for bringing up that motion. We felt that the membership did not want the dinner. We have had such poor cooperation along certain lines and they seemed not to want to do what they were asked to do, and we had come to feel that the annual dinner was no longer wanted.

The Chair called for a voice vote.

Motion not carried.

Dr. Langley: We will endeavor to continue the Annual Dinner.

Resolution

Annual Dinner

WHEREAS, it has been the usual custom to have an annual dinner at the yearly meeting of the Florida Medical Association, be it resolved that the annual dinner of the Florida Medical Association meeting be continued.

Resolution adopted by the Escambia County Medical Society on April 9, 1957.

Respectfully submitted,
Pascal G. Batson Jr., *Secretary*
Escambia County Medical Society

Dr. Dowlen: "The letter from the Orange County Medical Society regarding Senator Smathers' Senate Bill No. 727 'Scholarships for children of veterans,' is approved with the recommendation that the FMA go on record as opposing this bill.

"Mr. President, I move the adoption of this portion of the report."

Seconded by Dr. Steward.

Motion carried.

May 2, 1957

Florida Medical Association
P.O. Box 2411
Jacksonville, Florida
Gentlemen:

At the regular monthly meeting of the Orange County Medical Society on April 17, 1957, Senator Smathers' Bill S. 727 "To provide for the investment of certain funds obtained under the provisions of the Trading With the Enemy Act, and to provide for the use of interest from such investments for scientific scholarships and fellowships for children of veterans" was presented by the Chairman of the Legislation Committee.

Following a discussion, it was felt the Society should go on record as expressing opposition to this bill which in its intent sets up a privileged class. Furthermore, it was moved and seconded that the action of our Society be communicated to the House of Delegates of the Florida Medical Association and to the Florida Committee for Better Government.

Very truly yours,
(Signed)
W. Ansell Derrick, M.D., *Secretary*

"Mr. President, I move the adoption of the whole report, as amended."

Seconded by Dr. Patterson.

Motion carried.

Dr. Day presented Life Membership certificates to other Life Members who had arrived after the first presentation.

The Chair recognized Dr. Chas. J. Collins, of Orange.

Dr. Collins: "I understand that three of our past presidents were unable to be present because of unfortunate circumstances. Dr. Robert B. McIver is ill, Dr. John S. McEwan is in the hospital and Dr. Walter C. Payne Sr. could not be here on account of an accident to Mrs. Payne. I move that the Secretary send a telegram to each conveying our wishes for a speedy recovery.

Seconded by Dr. Sinnott.

Motion carried.

Dr. Langley: "It is now eleven-thirty. We will recess until 12:00 noon, when we will have our election of officers."

Dr. H. Phillip Hampton: "I move that the rules be suspended so that we may hold the election now."

Seconded by Dr. Madison R. Pope.

Motion carried by required two-thirds majority.

Dr. Langley asked for nominations for the office of President-Elect and recognized Dr. James R. Boulware Jr., of Polk.

Dr. Boulware: "Mr. President and Fellows of the House of Delegates:

"It is with extreme pleasure that I place in nomination for the office of President-Elect of the Florida Medical Association the name of a very dear friend. I have known him for twenty years, and have learned to admire his ability, his

sincerity, his community spirit, and his willingness to undertake any assignment for the benefit of organized medicine.

He was graduated from Cornell College in Iowa, and received his medical degree from the University of Minnesota. Following an internship at the Minneapolis General Hospital, he obtained a three-year Fellowship at the Mayo Clinic, and in 1938 became associated with the Watson Clinic in Lakeland.

He served as Secretary of the Polk County Medical Association both before and after his 5-year tour of duty in the Army Medical Corp, became President and is now a Trustee. He has been a delegate to the Florida Medical meeting for many years, serving on many reference committees.

He is an associate Editor of our Journal, and has served on the Scientific Work Committee for several years, and on your Board of Governors. At present he is also Chairman of the Florida Medical Committee on Nursing, is a member of the Committee on Fee Schedule for Military Dependents, a Director and on the Executive Committee of Blue Shield, and is a member of the State Hospital Advisory Council.

Professionally, he holds memberships in many organizations. He is a Diplomate of the American Board of Internal Medicine; is a member of the American College of Physicians; a member of the American College of Cardiology; and a member of the American Gastroscopic Society.

Not only has this doctor shown his ability and willingness to work for organized medicine, but he is an example of that type of doctor who believes a doctor should be a citizen and a leader in his community. He is Vice-President of the Chamber of Commerce, a member of the Board of Trustees of the Guidance Center, Chairman of Health and Safety of the District Boy Scouts, Advisor to the local Chapter of Red Cross, Medical Director of the Polk County Civil Defense, and the District Chairman of the Florida Medical Committee for Better Government.

Mr. President, I have the honor and privilege of placing in nomination for President-Elect of the Florida Medical Association—Dr. Jere Wright Annis of Lakeland."

Dr. Patterson: "On behalf of the Hillsborough County Medical Association, I would like to second the nomination of Dr. Jere Annis of Lakeland. We know Jere better than many other groups and our society went on record unanimously as endorsing his candidacy. You all know of his outstanding accomplishments in the Florida Medical Association. I am sure if given this high honor Dr. Annis will bring further greatness to the Florida Medical Association."

Dr. Leo M. Wachtel: "The delegation from Duval received no instructions on coming to this House of Delegates, except to vote for Jere Annis."

Dr. Donald F. Marion: "I would like to express the feeling of Dade County Medical Association in seconding this nomination."

Dr. Chas. J. Collins: "Orange County takes great pleasure in seconding this nomination."

Dr. Wachtel: "I move that nominations be closed."

Seconded by Dr. Franklin J. Evans.

Motion carried.

Dr. Langley asked Dr. Marion Hester and Dr. Charles Larsen Jr. to escort Dr. Annis to the rostrum.

Dr. Annis: "I am very much honored and very much scared—scared for both you and myself. I will try to do a good job for you. I will obviously need your help and friendship and something comes to my mind that my father-in-law told me. Some 70 years ago, he was being sent to Colorado for what they thought was TB and he objected because he was morbidly afraid of snakes. He spoke to his father who tried to reassure him that he would probably never be bitten, but even if he were bitten, something could be done about it. He said, 'Suppose a snake bites you on the wrist, you just suck out the venom and spit it out.' But the boy asked, 'What if he bites me in the seat of the pants,' to which the father replied, 'Son, that's when you find out who your real friends are.' "

Dr. Langley asked for nominations for First Vice President.

Dr. Cole: "For the office of First Vice President, we need someone with ability and experience. This has been exemplified by President Eisenhower, who has given Vice President Nixon so many duties. There is a parallel situation in our organization. I have in mind a man whose training, experience and devotion to duty makes him eminently suitable, Dr. Ralph W. Jack, of Miami."

Dr. George F. Schmitt Jr. moved that nominations be closed.

Seconded by Dr. Franklin J. Evans.

Motion carried.

The Chair called for nominations for Second Vice President.

Dr. Richard A. Mills: "I would like to place in nomination the name of Dr. Walter E. Murphree, of Gainesville, whose work in our organization is very well known.

It was moved that nominations be closed.

Seconded and carried.

Dr. Langley asked for nominations for Third Vice President.

Dr. Francis T. Holland: "I would like to nominate Dr. James T. Cook Jr., of Marianna."

Dr. Alpheus T. Kennedy moved that nominations be closed.

Seconded and carried.

The Chair called for nominations for Secretary-Treasurer.

Dr. Ralph S. Sappenfield: "I have no desire to run for any office in this Association; just the privilege of coming to this meeting this year to offer in nomination the name of Sam Day as Secretary-Treasurer of the Florida Medical Association."

Dr. Steward moved that nominations be closed.

Seconded and carried.

Dr. Langley: "Nominations for the Editor of the Journal are now open."

Dr. David R. Murphey Jr.: "It is usually customary to enumerate the accomplishments of a candidate in such a manner that all that needs to be added is a date for it to be a suitable obituary. In the case of my candidate, such a dissertation on his accomplishments is not necessary. He has been Editor of The Journal continuously since 1925 with the exception of three years when he was relieved of this obligation to serve you as President-Elect and President.

"Our Journal is outstanding among state medical journals. It is with great pleasure that I place in nomination the name of our distinguished editor, Dr. Shaler Richardson of Duval County."

Dr. Patterson moved that nominations be closed.

Seconded by Dr. Collins.

Motion carried.

Dr. John D. Milton: "Since we have had all of the officers nominated, I move that we elect them to their respective posts."

Seconded by Dr. Jelks.

Motion carried.

Dr. Langley: "My parliamentarian told me that it was not necessary to have the secretary cast a ballot."

"I would like to ask Dr. Herbert L. Bryans and Dr. David R. Murphey Jr. to escort Dr. Roberts to the Chair."

"Dr. Roberts, it is a great pleasure to welcome you. The best I can wish for you is that you will have the support during your administration that I have had. It will give you the best feeling in the world and you have my best personal wishes. It is my pleasure to present your gavel and turn over to you the reins of office."

Dr. Roberts: "Dr. Langley, Members of the Florida Medical Association, Distinguished Guests: I am in the same fix I was in last year when you gave me this high honor. Through the years I thought I had courage, but last year you just knocked the courage out of me. During my year as president-elect, I have had such wonderful and enthusiastic response to my requests for members to serve on committees, that I am now gaining a little more courage. When Dr. Langley tells me what excellent cooperation he has had, I grow taller in the saddle.

"Through the year, I realize that we are going to have trials and tribulations. We will have many problems; we already have them. It will be my duty often to make decisions when I won't have the advice of the Board of Governors or the Councilors; but, I promise you that I will not make a decision of any kind that will materially affect the Florida Medical Association until I have secured the best advice possible in this entire Association.

"I know for sure when I get to the end of the line next year, I will be plenty 'frazzed.' I may be lame, maimed, dead. I know for sure I will be 'broke.' But please, may I ask, when I am through, don't wear me out to a 'frazzle' like you have John Milton.

"I am going to try to serve as your president fair and square.

"Saturday last a very historic race took place, the eighty-third running of the Kentucky Derby. Coincidentally we have a doctor in our audience who has run that many races. You saw her get her certificate. Further, coincidentally, the Florida Medical Association has just run its eighty-third race. The Kentucky Derby came up with a winner by a nose—a photo finish—but the eighty-third race of the Florida Medical Association came up with a winner and he did not win by a nose. He won so far out on the track that when he hit the wire you could not tell there was anybody else in the race. That winner was Dr. Francis Langley. I know for sure I will not

be able to fill his shoes but I certainly hope I can at least try on his bedroom slippers occasionally. Dr. Langley has served you better than you know. He is not the type of man that does a lot of 'yak-yaking' like your present president. When he speaks, he knows what he is speaking about. I don't think that we will ever have a president that will do a better job for your Association than Dr. Francis Langley. So, the old adage that a good beginning makes a bad ending, I want you to help me prove that it isn't true. One of the finest things that will happen to me this year is the privilege of presenting to Dr. Francis Langley his Certificate of Honor for having served us well.

"The Past President's pin is worn by those who have earned the right to wear these buttons. They are not big enough; they should be lard can size so that everyone would know what these men have done for the Association. It grieves me that I don't see lots of them around, because there have been many given. It puts the stamp of approval on Francis Langley.

"Francis, I want you to know you have earned the right to wear this stamp of approval and I am not going to relegate you to pasture. Since you have won this race, you are still going to stay in there and pitch and in the future you will win many more races."

Dr. Langley: "It is with a feeling of great emotion that I step down from the Chair, but believe me, I have no doubt about the future of the Florida Medical Association with Dr. Roberts at the head, and his successor and the successors through the years. Thank you so much for the honor and for the help you have given."

Dr. Roberts: "We know that our problems are going to be tough, but we must build a strong organization. It will be my goal this year to get the county medical societies really organized and the county organizations will make FMA strong. When we are strong enough, we will not be divided in our own camp, and we can laugh at opposition. The eyes of the nation are on Florida. Our actions in the last few years in fighting the socializing of medicine have been holding actions. Holding actions are good in war but they do not win battles. I want the Florida Medical Association to take thought of that, talk these things over in your county medical societies. We have got to have it; we must have it.

Dr. Roberts announced that there would be a meeting of the Board of Governors in the Windsor Room immediately following adjournment.

Dr. Richard A. Mills announced that the Broward County Medical Association would like to invite any interested physicians to attend its next regular meeting to hear a special guest speaker.

On motion by Dr. Sias, duly seconded and carried, the Eighty-Third Annual Meeting was adjourned at 12:10 p.m.

Scientific Assemblies

The First Scientific Assembly convened at 9:30 a.m., Tuesday, May 7, in the Pageant Room, Hollywood Beach Hotel, with Drs. Donald F. Marion of Miami and George T. Harrell Jr. of Gainesville presiding. The following papers were read and discussed:

"Toxoplasmosis, Congenital and Acquired; Ocular Manifestations," Sherman B. Forbes, Tampa.

"Hazards in the Management of Peptic Ulcer with Anticholinergic Drugs: A Reemphasis," Hyman J. Roberts, West Palm Beach.

"Diffuse Idiopathic Pulmonary Fibrosis," Augustus E. Anderson Jr., Jacksonville, and G. Leonard Emmel, Gainesville. Presented by Dr. Anderson.

"Surgical and Physiologic Consideration in the Development of an Artificial Heart-Lung for Clinical Use," Robert S. Litwak , Miami.

"Value of Combined Heart Catheterization in the Selection of Patients for Valvular Heart Surgery," Philip Samet, Miami Beach.

"Complications of Acquired Diseases of the Aorta," Samuel M. Day, Jacksonville.

The Second Scientific Assembly convened at 2:00 p.m., Tuesday, May 7, in the Pageant Room, Hollywood Beach Hotel, with Drs. Charles McD. Harris Jr. of West Palm Beach and Richard Reeser Jr. of St. Petersburg presiding. The following papers were read and discussed:

"Transplantation of the Ureters into on Isolated Illeal Loop," J. Harold Newman, Jacksonville.

"Reconstructive Arterial Surgery," James D. Moody, Orlando.

"Facial Fractures, Their Recognition and Management," Bernard L. N. Morgan, Jacksonville.

"Incidence of Skin Cancer Arising from Precancerous Dermatoses," Wesley W. Wilson, Tampa.

"Sarcoma Botryoides," Howard C. Duckett, Jacksonville.

"New Technics in the Study of Carcinoma of the Uterine Cervix," Sam W. Denham, Jacksonville.

REGISTRATION

The registration for the 83rd annual meeting at Hollywood far exceeded that of any previous Convention of the Association. The total number registered was 2,108. The registrants include 988 members of the Association, 200 visiting physicians, 101 other guests, 507 members and guests of the Woman's Auxiliary, 25 scientific exhibitors and 287 representatives of exhibiting firms. There were 22 other states and 1 foreign country represented.

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MIAMI BEACH: Richard G. Alper, Michael A. Cogan, Lee W. Elgin Jr., Joseph Harris, Lewis A. Shepperd, Raymond J. Simmons, Melvin M. Sylvan, Rudolph T. Wagner, Jack Widrich.

OAKLAND PARK: Robert B. Walker. OCALA: William C. Butscher Jr. OPA LOCKA: Karl Y. R. Brook. PALM BEACH: Max R. Rubenstein, John Van Boven III. PERRINE: Alfred Glattauer. POMPANO BEACH: Max Klinghoffer. RAIFORD: Charles W. Bush. ST. PETERSBURG: Milton B. Cole, Charles C. Yerbury. SOUTH MIAMI: M. David Sims. TAMPA: William M. Douglas, James Gibson, William B. Hopkins Jr., William B. King, Lawence A. Ratchford, Manuel F. Rubio, Henry L. Wright Jr. WEST HOLLYWOOD: Milton G. Abarbanel. WEST PALM BEACH: John D. Bacon, James R. Brandon, Maximilian A. Crispin, Richard D. Hoover, George J. Nassef, Loren M. Rosenbach, Malcolm S. Van De Water.

CALIFORNIA-SALINAS: Fredk. W. Kraft. WATSONVILLE: James F. Culver. COLORADO-DENVER: M. Ray Gottesfeld, Bernard C. Sherbok. DISTRICT OF COLUMBIA-WASHINGTON: Bruce W. Halstead, G. Foard McGinnes. GEORGIA-AUGUSTA: Thos. P. Findley Jr. SAVANNAH: Walter Kanter. ILLINOIS-CHICAGO: Bernard V. Chern, Ernest B. Howard, Edward J. Levine, Julius I. Mandel, Jack H. Sloan, Jerrold Widran. DECATUR: Jack O. Spicer. INDIANA-EVANSVILLE: Thomas H. Nichols. FORT WAYNE: Leland J. Mortenson, John H. Nill, Donald S. Painter. INDIANAPOLIS: Robert F. Nagan. SOUTH BEND: Raymond A. Gaffney. KENTUCKY-LOUISVILLE: Meyer M. Harrison. MORGANFIELD: John P. Welborn Jr. LOUISIANA-NEW ORLEANS: A. Seldon Mann. SHREVEPORT: Joseph S. Shavin. MARYLAND-BETHESDA: John R. Heller. SILVER SPRING: Louis R. Long. MASSACHUSETTS-BUZZARDS BAY: Abram Krakower. MICHIGAN-DEARBORN: Andrew H. Bracken. DETROIT: Russell P. Bolton Jr., Stephen Malina. HUDSON: Arnold O. Abraham. JACKSON: Henry W. Sill. YPSILANTI: Donald W. Martin. MINNESOTA-MINNEAPOLIS: Robert R. Cooper, Charles E. Merket. ST. PAUL: Richard O. Leavenworth

MISSOURI-ST. LOUIS: Maurice J. Keller. NEW HAMPSHIRE-MANCHESTER: Robt. Flanders. NEW JERSEY-PATERSON: Francis R. Meyers. SOUTH ORANGE: Milton W. Amster. NORTH CAROLINA-DURHAM: Emil B. Cekada, Wiley D. Forbus. LINCOLNTON: John H. Fitzgerald Jr., Boyce P. Griggs.

NEW YORK-BUFFALO: Clarence A. Straubinger. JAMESTOWN: Harold M. Childress. NIAGARA FALLS: Richard A. Baer. POUGHKEEPSIE: Oleksei A. Leonidoff. NEW YORK CITY: Victor Baum, Henry W. Cave, William T. Robinson, Marilyn T. Schittone. OHIO-CINCINNATI: O. Herman Dreskin, Lawrence F. Gibboney. CLEVELAND: Victor C. Laughlin, Milton Linden, Alexander P. Orfirer. COLUMBUS: Reuben B. Hoover. CUYAHOGA FALLS: Robert J. F. Burkhard. LYNCHBURG: John G. Anderson. YOUNGSTOWN: Edwin R. Brody, Robert B. Poling. PENNSYLVANIA-PITTSBURGH: Leonard M. Cohen, Geo. E. Crum, Anthony J. Nicolette. MCKEESPORT: Richard H. Parks. SOUTH CAROLINA-CHARLESTON HEIGHTS: Alvin L. Rittenberg. TENNESSEE-MEMPHIS: Lemuel W. Diggs. WISCONSIN-CUDAHY: Manfred Landsberg. MILWAUKEE: Timothy T. Couch, Robert B. Pittelkow, Henry Rettig. CANADA-SUDBURY-ONTARIO: Jean M. Cloutier.

ANNUAL JOINT REPORT

Secretary-Treasurer, Samuel M. Day, M.D.
Managing Director, Ernest R. Gibson

The administrative year of 1956-1957 was of historic significance to the Association. For the first time in its eighty-three years it has its own home. The attractive headquarters building at 735 Riverside Avenue, Jacksonville, was first occupied on August 15, 1956 with formal dedication one month later.

It has exceeded expectations functionally and the efficiency of operation has been noticeably increased. It is surprising to note the increase in telephone calls, visitors and correspondence now that the name of the Association is exposed to constant public view. The Board Room is in use frequently for meetings of Association, allied and ancillary groups.

The tangible value of the building is shown in Exhibit "A," under assets, of the financial statement included in this report.

Following is a summarization of the activities of the departments which make up the executive office.

PUBLICATIONS

The Department of Publications continues with its assigned duties of publishing The Journal, under direction of the Editor and Managing Editor, preparation and distribution of the Association's newsletter "Briefs," multilithing publishing the Florida Medical Directory, House of Delegates Handbooks, programs for the annual and the district meetings and the mailing of the quarterly Journal of the Florida Academy of General Practice.

Mr. Tom Jarvis supervises the Department and serves as Assistant Managing Editor of The Journal. He is assisted by Mrs. Louise Rader, Journal technician. Mrs Edith B. Hill assists in publication of The Journal as editorial consultant.

The Journal

Actual production cost of The Journal this fiscal year amounted to $30,342.19. This figure does not include salaries because duties of employees include work in relation to other departments. Income from advertising, subscriptions from non-members and miscellaneous sales amount to $29,870.10. Income from allocation of subscriptions from dues paid by members totaled $14,010.00.

This year, 40,475 copies of The Journal were printed, an increase of 2,200 copies over the previous year. An effort is made to supply back issues when requested. This is not always possible because only a small supply of each

issue remains after each subscriber has been provided a copy.

"Briefs"

Thirteen issues of "Briefs" have been printed and mailed to members this year by the Department. Information of particularly current value to members, prompting each issue, may be drawn from the Managing Director or Supervisor of the Bureau of Public Relations. Copy for the issue is not always prepared by this Department.

Multilithing

Printing by the Department has been forms, reports, booklets, letters and the Auxiliary Yearbook. The Department also printed a revision of the VA. Fee Schedule which severely taxed the facilities.

Directory

A total of 4,500 copies of the 1957 Florida Medical Directory was printed at a cost of $3,342.45. Each Association member was sent a copy. Most of the remainder has been or will be sold for $2.00 per copy. Revenue from individual sales and advertising in the 1956 Directory amounted to $2,872.00. Copy for all rosters is provided by the Administration Department. Design, artwork and layout is done by the Department of Publications.

House of Delegates Handbook

Reports from the various Association committees; the agenda of the House of Delegates' meetings and the list of delegates, both provided by the Administration, is utilized by this Department in production of the Handbook.

Programs

Type used originally in The Journal is used again in production by this Department of programs for the Annual Meeting and for the Medical District Meetings. Design, artwork and layout is done by the Department. Copy for all programs is prepared by the Department from material provided by Administration.

Journal of the Florida Academy of General Practice

Mailing facilities of the Association are utilized by the Department in distributing quarterly the Journal of the Florida Academy of General Practice. At the request of the Academy, the Department performs this service at an agreed rate of two cents per copy, the approximate cost of the service.

PUBLIC RELATIONS

The policies of the Bureau of Public Relations are determined by the Board of Governors and implemented through its liaison member for public relations and the Committee on Legislation and Public Policy. The Bureau is directed by Mr. W. Harold Parham, Supervisor, who also serves as the Association's Assistant Managing Director. He is assisted by Mr. Eugene L. Nixon. Miss June Palmer serves as Bureau secretary.

Although several varied projects were undertaken during the past year, the primary activities of the Bureau have been concerned with planning, promoting and coordinating the Association's public relations and legislative programs and assisting county medical societies with local programs.

Field Work

As in previous years, much of the staff's time has been devoted to field work. Countless contacts were made with county society officers and committee chairmen, pubic officials, news media, organizations, agencies and individuals in efforts to achieve increased understanding and implementation of the Association's policies.

Florida Medical Foundation

During the year, the Bureau was called upon to assist in implementing the establishment of the Florida Medical Foundation. Facilities of the Bureau are continuing to be utilized in its administration.

Legislation

Continued emphasis was placed upon assisting the Committee on Legislation and Public Policy in carrying out activities relating to national legislation and the Association's state legislative program. Considerable time and effort were devoted by the staff in supporting the program of Governor LeRoy Collins to abolish the practice of naturopathy in Florida. An office was maintained in Tallahassee during the 1957 session of the Florida Legislature through which information pertaining to the Association's legislative program was provided to legislators. As in the past, a constant check was maintained on all health and medical legislation introduced during the session.

Science Fairs

A new project initiated by the Association this year was in the field of science fairs. Special Association awards were presented to winning junior and senior high school students whose exhibits showed the best aptitude for the medical sciences in the State Science Fair held in Gainesville. Winners were selected by a judging committee of physicians.

Rural Health

As an outgrowth of the continuing statewide program in rural health, the Association took the leadership last year in the creation of a new joint state rural health committee. The Florida Committee on Rural Health is composed of representatives of the Agricultural Extension Service of the two state universities, the Florida Farm Bureau Federation, the State Board of Health and the Association. Dr. Francis T. Holland, of Tallahassee, was elected as the Committee's first chairman. The Committee is expected to provide increased effectiveness of leadership, planning and co-ordination in the state rural health program.

Exhibits and Displays

Assistance was provided to county medical societies in presenting health displays at the Pensacola Interstate Fair, Pensacola; North Florida Fair, Tallahassee; Florida State Fair, Tampa, and Central Florida Fair, Orlando. The Florida State Fair exhibit was a joint project of the Association and the local county medical society. The favorable public response to these exhibits continued to emphasize the importance of the fair exhibit as a health education and public relations medium.

Other Projects

Other projects now underway or continuing include a statewide poliomyelitis immunization campaign, a program of cooperation between physicians and attorneys and a study of organized labor as it relates to medical practice.

Public Information

All publicity concerning the Association's activities was prepared or processed by the Bureau. The popular weekly column "Health Topics" has continued to bring authentic medical information to the public. A monthly health column was begun in the state's leading farm magazine. As a result of increased public interest in health and medicine, the Bureau has been called upon frequently to interpret and explain medical events to representatives of the popular news media. Transcribed radio programs and films for television and private showing were distributed throughout the state in cooperation with county medical societies.

The Bureau has assisted other committees of the Association and county medical societies upon request. The facilities of the Bureau are available at all times for use by the county societies in planning and implementing local programs.

ADMINISTRATION

This division of the headquarters office carried out the many directives of the House of Delegates, Board of Governors and Managing Director and it is the responsibility of this department to see that other members of the staff are kept advised of the numerous current programs as well as problems which present themselves from day to day.

Among the many important activities of this department are: bookkeeping and accounting records, purchasing, inventory of stock and all correspondence files. All billing for journal and directory advertising and for technical exhibit space is handled here. All work in the administrative department is handled by six staff members

under supervision of Mrs. Zoe Pack, office manager. Other members of this department are Mrs. Mae Mason, assistant office manager, Miss Frances Pesce, bookkeeper and Mrs. Janice Goin, Mrs. Berwyn Binkley, Mrs. Rita Fitzgerald, steno-clerks.

Membership Records

The records of the approximately 6,900 licensed doctors, with additional records for over 3,000 members, including an addressograph mailing list are maintained. The net gain in membership for the year was 160.

Annual Meeting

Before one annual meeting is over, plans and arrangements are underway in connection with the next one. This includes many contacts with specialty groups, the chairman of the Scientific Work Committee, technical exhibitors, guests, essayists and others. A large volume of correspondence, telephone calls and personal contacts are required between this office and the Convention Hotel to complete the many details required for a large meeting. Each of our annual meetings is greatly enhanced by the participation of the many drug, surgical and speciality firms who spare no expense in presenting a vast array of the latest scientific developments and technics. The gross proceeds from technical exhibit space, $17,030 for the current fiscal year, add substantially to the Association's income. During the meeting stenographic and clerical duties are performed by members of our staff in connection with registration, House of Delegates and scientific sessions as well as the reference committee meetings. The assembled material is transcribed, checked, edited and turned over to the Publications Department for publication in the Proceedings Number of The Journal.

Orientation

Each new member of the Association is furnished several phamphlets to acquaint him with the purposes and activities of the Association and we stand ready to assist him in every way possible upon request.

Placement

We maintain listings of communities seeking doctors as well as those doctors who are looking for locations in Florida. A steadly increasing number of doctors call at the office where they have the opportunity of reviewing our complete files on the various locations available.

Board and Committee Meetings

Stenographic services are rendered the Board of Governors, Executive Committee and the several committees who hold meetings throughout the year. This includes notification of meeting dates as well as the transcription and duplication of the minutes. A large volume of correspondence results from the many directives.

Multilith Reproduction

All masters are typed in this department for "Briefs," the Yearbook of the Woman's Auxiliary, the County Committee Booklet, state and AMA rosters, record cards, forms and form letters.

Special Services

On request, envelopes are addressed and stuffed covering our complete membership for doctors and allied organizations. A charge is made for this service.

Directory

Each year all copy for the Florida Medical Directory is prepared and the printer's proof checked for errors before turning this information over to the Publications Department. All Florida licensed non-members are contacted by form letter to verify address and determine whether or not they wish to purchase directories.

Miscellaneous Activities

Local and long distance calls, Western Union messages, all incoming mail and packages and the major portion of these outgoing items are handled in this department. All visitors are greeted by a receptionist. It is the responsibility of the Office Manager to work closely with the building custodian relative to the maintenance and care of the building and grounds.

Finances

Assets of the Association for the fiscal year ending March 28, 1957 total $294,992.77, of which $177,896.76 is in real estate, building and equipment. Cost of operation continues to advance with constantly increasing prices for supplies and services.

The financial statements appearing at the end of this report are published for the information of the members. The books and records of the Association are open to members and we will gladly endeavor to answer inquiries of any nature upon request. The books have been audited by Goodrich and Varnedoe, Certified Public Accountants, and a certificate of the audit is incorporated in the statements which follow.

Respectfully submitted,

Samuel M. Day, M.D., Secretary-Treasurer
Ernest R. Gibson, Managing Director

Dr. Samuel M. Day, Secy.-Treas.
Florida Medical Association
Jacksonville, Florida

Dear Sir:

In compliance with request of Mr. Ernest R. Gibson, Managing Director, Florida Medical Association, we have examined the books of account, vouchers and other records of the association, maintained in his office, for the period March 21, 1956 to and including March 20, 1957, and submit herewith our report consisting of:

EXHIBIT "A"— Balance Sheet, March 20, 1957

EXHIBIT "B"— Income Statement from March 21, 1956 Through March 20, 1957

SCHEDULE "B-1"— Schedule of Expense

EXHIBIT "C" — Schedule of Investments, March 20, 1957

EXHIBIT "D"— Schedule of Additions to Fixed Assets

We determined that all recorded receipts were deposited to the credit of the association, and that the disbursements appeared to be for proper purposes. The item on the liabilities side of Exhibit "A", under caption "Reserve For Deferred Income" is the aggregate of the membership dues unpaid as at March 20, 1957 and the amount due the Journal Fund by advertisers.

The investments in U. S. Treasury Bonds were verified by actual count in the safe deposit vault. Matured interest coupons totaling $400.00 were attached to bonds on date of verification.

Construction of the permanent quarters of the association was completed in 1956. The total cost of the building amounted to $122,708.52.

The form of our report this year is different from those submitted in prior years. This change, we feel, will be more in keeping with current acounting trends and will serve to convey more readily the operating results of the association.

We made no attempt to verify amounts due from various county societies or by advertisers in the Journal.

Yours very truly,

(Signed) Goodrich & Varnedoe
Certified Public Accountants

CHG/d

(See following pages for Exhibits A, B, B-1, C and D referred to in above letter.)

Exhibit "A"
BALANCE SHEET
March 20, 1957

ASSETS

CURRENT ASSETS			
Cash:			
Atlantic National Bank		$ 35,135.23	
Florida National Bank		8,556.55	
Petty Cash Fund		50.00	$ 43,741.78
Accounts Receivable:			
Due from County Societies—Dues		$ 48,520.00	
Due from Journal Advertisers		6,028.76	54,548.76
Inventory—Stationery, Etc.			2,650.10
TOTAL CURRENT ASSETS			$100,940.64
INVESTMENTS			
U. S. Treasury Bonds—From Exhibit "C"			16,155.37
FIXED ASSETS			
	COST	ACCUMULATED DEPRECIATION	BOOK VALUE
Land	$ 35,833.31	$	$ 35,833.31
Office Building	122,708.52	2,147.39	120,561.13
Furniture, Fixtures & Equipment	32,857.51	11,355.19	21,502.32
	$191,399.34	$ 13,502.58	177,896.76
TOTAL ASSETS			$294,992.77

LIABILITIES AND NET WORTH

CURRENT LIABILITIES			
Reserve for Deferred Income			$ 54,548.76
NET WORTH			
Balanced—March 20, 1956		$217,106.90	
Net Gain for Year—Exhibit "B"		23,337.11	
Balance—March 20, 1957			240,444.01
TOTAL LIABILITIES AND NET WORTH			$294,992.77

Exhibit "B"
INCOME STATEMENT
For The Period March 21, 1956 Through March 20, 1957

INCOME			
Dues — Delinquent		$49,080.00	
Current		63,560.00	$112,640.00
Entrance Fees			2,520.00
Advertising — Journal		$29,260.85	
— Directory		610.00	29,870.85
Journal Subscriptions & Sales			609.25
Directory Sales			2,262.00
Technical Exhibits			17,030.00
Reprints — Non-Member — Net			286.79
Interest Earned			8,234.49
Miscellaneous Income			1,556.20
TOTAL INCOME			$175,009.58
EXPENSE			
Administrative			$ 55,134.53
Public Relations			32,266.19
Publications			54,497.76
Building Operations			9,773.99
TOTAL EXPENSE			151,672.47
NET GAIN FOR PERIOD — To Exhibit "A"			$ 23,337.11

Schedule "B-1"

Schedule of Expenses

For The Period March 21, 1956 Through March 20, 1957

	ADMINISTRATIVE	PUBLIC RELATIONS	PUBLICATIONS	BUILDING OPERATIONS	TOTAL
Postage & Express	$ 1,285.05	$ 1,213.74	$ 1,284.20	$	$ 3,782.99
Office Supplies	287.19	1,172,11	752.10		2,211 40
Telephone & Telegraph	1,401.42	1,330.69	477.07		3,209 18
Travel Expense	1,417.93	3,457.63	65.63		4,941.19
Delegates To A.M.A. Convention	2,059.77				2,059.77
Office Rent	589.75	563.50	589.75		1,743.00
Maintenance—Office Equipment	325.36	221.74	246.74		793.84
Employees Insurance	183.85	97.30	66.60	17.70	365.45
Building Insurance				819.59	819 59
Federal & State Taxes	782.96	526.99	1,347.77	358.79	3,016 51
Books, Pamphlets, Etc.	335.99	531.97	289.84		1,157.80
Salaries	26,228.84	14.812.78	7,793.20	1,574.00	50,408.82
Contractor Fees	1,045.01	66.65	3,666.65		4,778.31
Pension Plan Premium	6,712.57	1,168.50	951.83		8,832.90
President's Expense Fund	311.87				311.87
Secretary's Expense Fund	69.33				69.33
Printing & Engraving	938.44	1,193.70	2,057.45		4,189.59
Convention Expense—Net Expense	6,712.23				6,712.23
Committee Expense	1,999.32				1,999 32
Dues	218.00	236.50			454.50
Miscellaneous	818.56	23.30	185.00	1,737.53	2,764.39
Patio Party—Net Expense	296.00				296.00
Medicare	204.57				204.57
Depreciation	910.52	456.48	11.07	3,149.47	4,536.54
Special Projects		1,877.04			1,877.04
Legislation—Public Policy		3,306.57			3,306.57
Printing Journal			31,452.86		31,452.86
Printing Directory			3,260.00		3,260.00
Utilities				949.03	949.03
Janitor's Supplies				1,167.88	1,167.88
TOTAL—To Exhibit "B"	$55,134.53	$32,266.19	$54,497.76	$9,773.99	$151,672.47

Exhibit "C"

Schedule of Investments

As of March 20, 1957

	DATE PURCHASED	MATURITY DATE	FACE VALUE	NUMBER OF BONDS	COST
U. S. Treasury Bonds	3/20/54	1962-67	$1,000.00	1	$ 978.44
U. S. Treasury Bonds	3/20/54	1962-67	5,000.00	3	15,176.93
TOTAL INVESTMENTS—To Exhibit "A"					$16,155.37

Exhibit "D"

Schedule of Additions to Fixed Assets

From March 21, 1956 Through March 20, 1957

	Land	Building	Furniture Fixtures & Equipment	Total
BALANCE — March 21, 1956	$ 34,716.31	$ 44,125.07	$ 21,543.39	$ 100,384.77
Additions	1,117.00	78,583.45	11,314.12	91,014.57
BALANCE — March 20, 1957	$ 35,833.31	$ 122,708.52	$ 32,857.51	$ 191,399.34

Exhibit "E"

Dues and Entrance Fees Collected March 21, 1956 Through March 20, 1957

NAME OF SOCIETY	TOTAL MEMBERS	MEMBERS NO. PAID	ARREARS NO. IN	1957 DUES COLLECTED	BACK DUES COLLECTED	ENTRANCE FEES
Alachua	63	58	5	2,040	640	70
Bay	29	22	7	800	1,080	30
Brevard	50	43	7	1,480	400	90
Broward	158	132	26	4,920	440	170
Collier	9	9	0	320		
Columbia	10	9	1	200		10
Dade	773	46	727	40	29,040	520
DeSoto-Hardee-Highlands-Glades	28	24	4	760	880	
Duval	324	193	131	6,120	5,920	270
Escambia	109	97	12	3,480	560	60
Franklin-Gulf	6	6	0	200		
Hillsborough	211	168	43	6,080	1,920	150
Indian River	10	10	0	320		
Jackson-Calhoun	17	17	0	600	40	
Lake	31	23	8	760	160	
Lee-Charlotte-Hendry	38	34	4	1,200	360	80
Leon-Gadsden-Liberty-Wakulla-Jefferson	72	39	33	1,280	560	60
Madison	7	5	2	120	80	
Manatee	29	29	0	1,000	200	10
Marion	34	7	27	40	280	20
Monroe	13	2	11		320	10
Nassau	9	8	1	240		
Orange	207	156	51	5,760	1,400	180
Palm Beach	156	136	20	4,960	840	100
Pasco-Hernando-Citrus	19	19	0	640	120	10
Pinellas	262	246	16	9,160	600	330
Polk	116	94	22	3,360	440	110
Putnam	11	10	1	280	40	10
St. Johns	21	21	0	720	40	10
St. Lucie-Okeechobee-Martin	25	19	6	720	160	20
Sarasota	70	66	4	2,440	40	70
Seminole	20	17	3	560	40	10
Suwannee	11	9	2	240	280	10
Taylor	5	5	0	120	40	10
Volusia	91	71	20	2,520	1,360	80
Walton-Okaloosa	22	3	19		720	20
Washington-Holmes	3	3	0	80	80	
Totals	3,069	1,856	1,213	63,560	49,080	2,520
Dues Not Payable:				49,080	Back Dues Collected	
Co., Soc. Secys.	37			112,080	Total Dues Collected	
Life	105			2,520	Entrance Fees Collected	
Excused	36			115,160	Dues and Entrance Fees	
Honorary	74					
Military Ser.	15	267				
Paying Dues		1,589				



Report of the Editor of The Journal

Shaler Richardson, M.D.

In continuing the improvements begun two years ago when The Journal was made a part of the Department of Publications, the major changes this year has been a gradual shift in editorial policy.

It has been the function of The Journal to record the activities of the Association and as a historical record to follow the Association's leadership. Thus The Journal served in a passive manner.

The Association is in a period of change and is rapidly becoming a vibrant organization which requires not a mere chronicler of its history, but also an active voice which can speak to the membership in an explanatory and advisory manner. The efforts of The Journal staff this year have been directed toward this end.

The feature editorial for each item was prepared by either an associate or an assistant editor on the subject which, in his opinion, should be presented. In some instances there has been disagreement because of the positive position, however by and large, the reception has been gratifying. So far only the readers who disagree have let us know. We hope the ones who remained silent thus signify their approval.

Following this feature editorial, we have made every attempt to report, before they have happened, the various projects and activities of the Association. Emphasis has been on scientific meetings which the physician might be interested in attending; on postgraduate courses given in the state that would provide him the opportunity to keep abreast of the newest technics without having to travel great distances.

Reports of postgraduate courses and other meetings scheduled for metropolitan medical centers have been published in the State News Items in order that physicians may be aware of them.

The shift in editorial policy does not mean The Journal will cease to record the history of the Association. We hope to be successful in both undertakings, as the official organ of the Association and the recorder of its history.

There have been changes in format and make-up. These were necessary for attractiveness and easier reading. More pictures have been used, and for the first time in The Journal's 42 years, a picture was used on the cover. Appropriately enough, the picture was of the Association's new headquarters building.

Last year, 54 scientific papers were published and 45 abstracts. The 12 issues totaled 1,278 pages. Total income was $28,005.89. Expenditures were $30,342.19. Salaries are not included in expenditures because staff members have duties other than publication of The Journal. Nor does the income figure include a $5.00 per member subscription allocation from dues. The Journal just about breaks even financially.

Sincere appreciation is expressed to the Assistant Editors, Drs. Webster Merritt and Franz H. Stewart, and to the Associate Editors, Drs. Louis M. Orr, Joseph J. Lowenthal, Jere W. Annis, Herschel G. Cole, Wilson T. Sowder, Carlos P. Lamar and Walter C. Payne Sr.

To Drs. Chas. J. Collins and James N. Patterson, members of the Committee on Publication, I also express sincere appreciation. One or both of them have read and approved each scientific paper published this year before it was referred to me.

I am indebted to Dr. Kenneth A. Morris, Chairman, and his assistant, Dr. Walter C. Jones, for the smooth functioning of the Abstract Department.

Mrs. Edith B. Hill, Editorial Consultant, has been constantly on the job. She has rendered valuable service and many Journal authors join with me in extending appreciation to her.

Mr. Ernest R. Gibson, Managing Editor, has directed the work of actual publication most efficiently. He has maintained the high standards established for The Journal and at the same time been alert to improvements. But, the real credit for the improved Journal with the new look goes to those who live and work with it constantly and continuously, forever fighting a deadline, Mr. Tom Jarvis, Assistant Managing Editor, and Mrs. Louise Rader, Technician.

For the past 29 years, it has been my privilege to be Editor of The Journal. I am grateful for the confidence the members of the Association have shown by thus honoring me year after year.





William Carmel Roberts, M.D.
President 1957-1958
Florida Medical Association

THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. Box 2411 Jacksonville, Florida

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William Carmel Roberts, M.D., President

Dr. William Carmel Roberts is a native of Wilcox County, Alabama. The son of William Pinson Roberts, M.D., and Ruby Estelle Youngblood Roberts, he was born at McWilliams on Oct. 19, 1905. He attended local elementary schools and was graduated from the Dothan High School at Dothan, Ala., in 1923. He received his academic training at the University of Alabama, where he was awarded the degree of Bachelor of Science in Medicine in 1928. He then turned to the neighboring state of Tennessee for his medical training. In 1930, the University of Tennessee College of Medicine conferred upon him the degree of Doctor of Medicine.

After completing an internship at St. Johns Hospital in Tulsa, Okla., Dr. Roberts returned to Tennessee in 1931. He received further training at Memphis General Hospital and the Baptist Hospital in Memphis. Some years later he engaged in postgraduate work at the Cook County Graduate School of Medicine in Chicago. His fraternities are Theta Kappa Psi and Pi Kappa Phi.

Dr. Roberts entered the private practice of medicine in Florida, locating in Panama City in 1932. He has continued to practice there to the present time, engaging in the specialty of obstetrics and gynecology.

From 1949 until 1956 he served as Chief of Staff of Bay Memorial Hospital, and during his term of office the hospital was fully accredited by the American College of Surgeons and the Joint Commission on Hospital Accreditation. In recognition of his services, the staff presented him with an engraved plaque. He is a member of the courtesy staff of Adams Hospital and Lisenby Hospital.

In 1933, soon after establishing his practice in Panama City, Dr. Roberts reorganized the Bay County Medical Society as an active component of the Florida Medical Association and served as its president during that year and also in 1936 and 1948. From 1938 to 1942 and in 1947 he held the office of secretary. From 1933 to 1941 and since 1946 he has been a delegate to the annual meetings of the state society.

Active in the Florida Medical Association for a quarter of a century, Dr. Roberts has served in

numerous capacities. His committee memberships have included Necrology, 1935; Representatives to Industrial Council, 1940; Woman's Auxiliary Advisory, 1940; and Medical Economics, 1952 to 1956. He was District Councilor in 1942 and from 1946 to 1948. In 1952 he was Chairman of the Council. He has served on the Board of Governors since 1954, and in 1956 was President-Elect. At present he is a member of the Medical Advisory Committee for the College of Medicine of the University of Florida. He also serves on the Board of Directors of Blue Shield of Florida, and as an ex officio member of the Board of Directors of the Florida State Chamber of Commerce.

Dr. Roberts is a fellow of the American College of Surgeons and of the International College of Surgeons. In addition, he is a founding fellow of the American College of Obstetrics and Gynecology and a senior fellow of the Southeastern Surgical Congress. He holds membership in the American Medical Association, the Southern Medical Association, the Gulf Coast Clinical Society, and the Florida Obstetric and Gynecologic Society.

During World War II, Dr. Roberts served in the Air Corps from 1942 to 1946 and was separated from the service with the rank of major. While with the 74th Field Hospital during the Okinawa Campaign, he made the first motion picture in color of war surgery up front. By invitation, this copyrighted film was shown and narrated by him on the scientific program of the International Postgraduate Medical Association of North America in 1948 and on the scientific program of the Section on General Practice of the American Medical Association in 1949. The War Department borrowed the film to aid in compiling a training film on war surgery. In addition to this valuable contribution, Dr. Roberts has contributed a number of articles to medical literature, all pertaining to his specialty.

Locally, Dr. Roberts has through the years been most active in civic and social affairs. A past president of the Panama City Kiwanis Club, he is also a past president of the Panama City Country Club and past commodore of the St. Andrew's Bay Yacht Club. He is a member of the board of trustees and a former chairman of the board of stewards of the First Methodist Church. His hobbies are quail hunting, golf and sailing.

Dr. Roberts and Mrs. Roberts, the former Miss Mary Ann Chaffee of Memphis, have one son, William Carmel Roberts Jr.

The 1957 Annual Meeting in Review

Several innovations featured the Eighty-Third Annual Meeting of the Florida Medical Association, held at the Hollywood Beach Hotel in Hollywood on May 5 to 8, 1957. Rearrangement of the program with a view to better organization of the Association's work during the annual convention was a major change which scheduled the first session of the House of Delegates on Sunday afternoon and the closing session on Wednesday morning. Monday was devoted to a general session in the morning, and in the afternoon a new feature was a closed circuit television program in conjunction with other state societies meeting concurrently. The annual meeting of Blue Shield of Florida followed the Videclinic. In order to permit the House of Delegates and the Reference Committees to meet without conflict with other activities, the scientific papers were all presented in a single day, the two sessions being held on Tuesday.

Highlighting the actions of the House of Delegates was the stand taken on the Medicare program. In expressing its disapproval of extending the Medicare contract, the House directed that the fixed fee schedule contract in effect at that time be terminated on June 30, 1957, and that a new contract, based on the physician's usual fee for services, be negotiated. It also stipulated that the Board of Governors devise a mechanism to provide dependents with medical care during the interim between contracts and that each county medical society establish a committee to handle problems related to Medicare.

The members of the Association were urged to make donations to the Florida Medical Foundation. It was pointed out that the Foundation hopes to get sizeable contributions from outside sources, but that others will not be interested until the doctors themselves contribute. Contributions may be directed wherever the donor

Officers 1957 - 1958



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Shaler Richardson, M.D., Jacksonville
Editor of The Journal

wishes them to go, within the broad provisions of the charter. It was recommended that each Association member be encouraged to donate $10 or more to the Foundation, which has a wonderful opportunity to render a great service.

The progress report on the Association's first group insurance, begun with the offering of its Disability Insurance and Catastrophic Hospitalization plans, contained a plea for wider participation of the members. When 60 per cent of the membership participates, the underwriter will no longer have to consider each individual application, and this coverage will be available to all members under 70 years of age. To reach this figure, the number of participants must be doubled. All members of the Association were urged to study the advantages of the Association plan and avail themselves promptly of its benefits so that these benefits may also become available to those members who are otherwise uninsurable.

Active support of the Jenkins-Keogh legislation under consideration by the Congress was urged. These bills, HR 9 and 10, would permit self-employed persons to establish annuities with deferred income tax provision. The importance of members advising their respective Congressmen and Senators of their wishes regarding these bills was stressed.

The House gave its approval to a change in name of two county medical societies in accordance with the request of members in the areas and as recommended by the Council. The Suwannee County Medical Society became the Suwannee-Hamilton-Lafayette County Medical Society, and the Walton-Okaloosa County Medical Society became the Walton-Okaloosa-Santa Rosa County Medical Society.

The House designated the newly formed Medical Schools Liaison Committee a subcommittee of the Committee on Medical Education and Hospitals. Its seven members are appointed by the President of the Association, who is to select one member from the medical faculty of the University of Miami School of Medicine and one from the medical faculty of the College of Medicine of the University of Florida, one member of the Dade County Medical Association and one member of the Alachua County Medical Society, one member from each of the other two medical districts of the Florida Medical Association other than where the medical schools are located, and one member from the Florida Medical Association at large.

Attention was directed to the appointment of Dr. William C. Thomas Jr., of Gainesville as Director of the Division of Postgraduate Education of the College of Medicine of the University of Florida, effective July 1, 1957. Appreciation of the unselfish and untiring efforts of Dr. Turner Z. Cason in promoting and directing the postgraduate work in the state for 26 years was expressed. Dr. Cason continues to head the Association's Committee on Medical Postgraduate Course, and the close cooperation between the Association, the Florida State Board of Health, and the College of Medicine in the presentation of postgraduate medical education is expected to continue.

The comprehensive and polished address of President Francis H. Langley reviewed the accomplishments of his year in office and made gracious acknowledgment of the excellent cooperation from many quarters which had sustained his administration. Among his constructive recommendations were a sound and effective revision of the Association's Constitution and By-Laws and careful scrutiny of the organization, procedures and policies of The Journal to determine how it can best serve the Association. His informative and stimulating address, concluding with a strong plea for union and solidarity within the profession, is published in this issue of The Journal and is recommended reading for every member of the Association.

The report of Mr. Marvin I. Baker, who represented the Florida Student Medical Association chapter of the College of Medicine of the University of Florida at the 1957 convention of the Student American Medical Association, informed Association members of the problems of medical education from the student viewpoint. These problems included sources of information on internships, the economic plight of married interns, malpractice suits against interns and residents, and the need of many medical students for financial aid. Appreciation was expressed to the Association for providing the opportunity for the Florida Student Medical Association to be represented at the national convention.

Among the innovations at this year's meeting was the institution of a custom that is timely. Life Members are now to receive a Life Membership Certificate. In recognition and appreciation of 35 years' service of active members, certificates will be awarded annually at the convention. The roll of Life Members was called, and certificates

were presented to those in attendance. Those not present were subsequently to receive their certificates by mail.

It was the consensus of the members that the custom of having an Annual Dinner be restored.

The President's guest speaker was Dr. Lemuel W. Diggs of the University of Tennessee College of Medicine, Memphis. Other eminent guests who addressed the convention were Dr. Ernest B. Howard, Assistant Secretary of the American Medical Association, Chicago, Dr. J. R. Heller, Director of the National Cancer Institute, Bethesda, Md., Dr. Thomas Findley of the Medical College of Georgia, Augusta, and Lt. Col. E. G. Rivas, MSC, Director, Liaison and Special Activities, Office to Dependents' Medical Care, Office of the Surgeon General, Department of the Army, Washington, D. C.

Dr. William C. Roberts, of Panama City, acceded to the presidency, succeeding Dr. Langley, of St. Petersburg. He will also serve as Chairman of the Board of Governors. The choice for President-Elect was Dr. Jere W. Annis, of Lakeland, who will assume the office of President at the 1958 Annual Meeting. Drs. Ralph W. Jack, of Miami, Walter E. Murphree, of Gainesville, and James T. Cook Jr., of Marianna, were elected Vice Presidents. Dr. Samuel M. Day, Secretary-Treasurer, and Dr. Shaler Richardson, Editor of The Journal, both of Jacksonville, were re-elected.

Of the 1,188 physicians in attendance, 988 were members of the Association and 200 were visiting doctors. Both the physician attendance and the total registration of 2,108 were records. The 1958 convention will be held at the Hotel Americana, Bal Harbour, adjacent to Miami Beach, and the dates set by the Board of Governors are May 10 to 14.



Board of Governors, 1957-1958. (Seated left to right) Dr. Samuel M. Day, Jacksonville; Dr. Jere W. Annis, Lakeland; Dr. William C. Roberts, Panama City; Dr. Francis H. Langley, St. Petersburg. (Standing left to right) Dr. Reuben B. Chrisman Jr., Miami; Dr. George S. Palmer, Tallahassee; Dr. Clyde O. Anderson, St. Petersburg; Dr. Meredith Mallory, Orlando; Dr. John D. Milton, Miami; Dr. Edward Jelks, Jacksonville; Dr. Eugene G. Peek Jr., Ocala, and Dr. Herbert L. Bryans, Pensacola.

Ophthalmologists Awarded Citations by Florida Council for the Blind

At the last meeting of the Blind Advisory Committee of the Florida Council for the Blind, it was recommended that the Council issue citations to all physicians of the Panel who have rendered services for five years or more. This committee, composed of outstanding blind citizens, evaluates and advises on policies and programs of the agency pertaining to the visually handicapped. It proposes this gesture in appreciation of the great amount of medical and surgical opthalmologic work that is rendered gratuitously by the members of the Panel. The ophthalmologists comprising the Panel take care of Council cases, performing examinations, rendering treatment and providing operative care for the patients.

The following ophthalmologists are listed for such citation: Drs. William H. Anderson Jr., Ocala; Edson J. Andrews, Tallahassee; Alan E. Bell, Pensacola; Bernard T. Bell, St. Petersburg; Curtis D. Benton Jr., Fort Lauderdale; Charles W. Boyd, Jacksonville; Henry E. Branca, Fort Pierce; Lee E. Bransford Jr., Jacksonville; James W. Clower Jr., Daytona Beach; Paul T. Cope, St. Petersburg; R. Renfro Duke, Tampa; G. Tayloe Gwathmey, Orlando; Chas. J. Heinberg, Pensacola; Marion W. Hester, Lakeland; Edward E. Hodsdon, Coral Gables; Ned W. Holland, Tampa; Hollis C. Ingram, Orlando; Garland M. Johnson, Fort Lauderdale; Odis G. Kendrick Jr., Tallahassee; George W. Lawson, Miami; Eric H. Lenholt, Daytona Beach; Albert G. Love IV, Gainesville; Blackburn W. Lowry, Tampa; Charles F. McCrory, Jacksonville; Thomas L. McKee, Fort Lauderdale; Orville N. Nelson, St. Petersburg; Manasseh B. Park, Coral Gables; Hugh E. Parsons, Tampa; Sherrel D. Patton, Sarasota; Anthony P. Perzia, Tampa; Younger A. Staton, West Palm Beach; Joseph W. Taylor Jr., Tampa; Joseph W. Taylor Sr., Tampa; Laurie R. Teasdale, West Palm Beach; Harold E. Wager, Panama City, and Frances C. Wilson, Tampa.

The Medical Advisory Committee of the Council will also be honored with citations. Its members are: Drs. Shaler Richardson, chairman, Jacksonville; Sherman B. Forbes, Tampa; Charles C. Grace, St. Augustine; Ralph E. Kirsch, Miami; Carl S. McLemore, Orlando; Robert M. Oliver, Miami; Nathan S. Rubin, Pensacola; William Y. Sayad, West Palm Beach; Francis C. Skilling, Miami, and Kenneth S. Whitmer, Miami.

Postgraduate Obstetric-Pediatric Seminar

The Postgraduate Obstetric-Pediatric Seminar, will be held again at the Daytona Plaza Hotel in Daytona Beach on September 9, 10 and 11, 1957. This is the seventh consecutive year for this seminar, which now has become one of the most popular meetings of its type in the southeastern United States. The former name, Tri-State Obstetric-Pediatric Seminar, has been changed because a fourth state, Alabama, has become associated with the group.

As in the past the program will consist of formal presentations on obstetric and pediatric subjects of current interest by some of the nation's leading medical figures. In addition, there will be the usual panel type discussion of questions submitted by the audience to a panel of experts. This is a particularly valuable meeting for pediatricians, obstetricians, gynecologists and those in general practice.

The meeting is jointly sponsored by the Bureaus of Maternal and Child Health of the State Health Departments of Florida, Georgia, South Carolina and Alabama, and the Maternal Welfare Committees of the four State Medical Associations. It is approved by the Academy of General Practice in Category II.

Florida Medical Association Golf Tournament

The annual Florida Medical Association Golf Tournament held at the Hollywood Beach Hotel course during the Eighty-Third Annual Convention was entered by 58 physicians, according to Dr. Curtis D. Benton Jr., of Fort Lauderdale, chairman of the Golf Committee.

Dr. Benton announced the names of the winners and awarded prizes at the Patio Party, Tuesday evening, May 7.

Dr. Edson J. Andrews, of Tallahassee, with an even par 70, was awarded the Duval County Medical Society Trophy for low gross. The other winners on gross scores were: 2nd, Dr. Julian A. Rickles, Miami; 3rd, Dr. Maxwell M. Sayet, Miami Beach ; 4th, Dr. Walter F. Davey, Stuart; 5th, Dr. Joseph L. Hundley, Orlando; 6th, Drs. William M. C. Wilhoit, Pensacola, J. Raymond Graves, Miami, and David W. Martin, West Palm Beach.

Dr. Paul J. McCloskey, of Tampa, won the Orlando Loving Cup for low net. The other win-

ners on low net scores were: 2nd, Dr. Curtis D. Benton Jr., Fort Lauderdale; 3rd, Dr. Joseph J. Ruskin, Tampa; 4th, Dr. Lloyd U. Lumpkin, Fort Lauderdale; 5th, Drs. Walter R. Newbern, West Palm Beach, and George H. Massey, Quincy.

In the tournament for members of the Woman's Auxiliary held concurrently under chairmanship of Mrs. Paul W. Hughes, of Fort Lauderdale, Mrs. Edson J. Andrews, of Tallahassee, won the Orange County Trophy for low gross score. Mrs. Robert C. Piper, of Coral Gables, was second. Winner for low net score was Mrs. Walter J. Newbern, of West Palm Beach, with Mrs. David W. Martin, also of West Palm Beach, second.

Engraved trophies were presented to the low gross and low net winners, men and women, in addition to the permanent trophies which are retained one year. Two dozen golf balls for prizes were presented by Eaton Laboratories and two dozen by Pfizer Laboratories. In addition, a stethoscope was presented by the Surgical Equipment Co. of Miami. Additional prizes were in the form of golfing merchandise, balls and shirts.

Ford Foundation 1956 Report

The Ford Foundation committed $602,000,000 in new grants and appropriations to its various philanthropic interests during the last fiscal year, according to its recently issued 1956 Annual Report. The year 1956 was a significant milestone in the development of the Foundation for in that period this great philanthropic organization more than doubled the dollar total of grants and appropriations undertaken in all its preceding history. It increased 10 times over the number of grantees which have received support.

In 1950, when the outline of its current program was determined, grantees of the Foundation were located in 28 communities of 16 states, and in one foreign country. By October 1956, there were Foundation grantees in some 2,500 communities in all 48 states and three territories, as well as in 54 foreign countries. Funds committed by the Foundation for all purposes since its establishment in 1936 totaled nearly $970,000.000 at the end of the 1956 fiscal year.

In the evolution and expansion of the Foundation's program, medical education has fared well. Particularly in 1956, the Foundation faced the question of what effective role it could essay in this field of education which most concerns the physical well-being of the nation but which has proved over a period of many years to be the most expensive.

"For the university administrator," the Annual Report stated, "the medical school is not only his costliest problem—on the average it costs about four times as much to train a medical student as a liberal arts student—but quite often his toughest and touchiest. There are many reasons for this. The medical school's faculty is large and its student body small. The courses are long and the facilities and equipment expensive. There is a constant problem in keeping teachers from the lucrative attractions of private practice.

"To help prevent the impairment of the nation's progress in medical science and to help meet the ever-expanding requirements of the schools upon which the people of the United States depend so heavily for their health services, the Foundation this year undertook two specific actions."

The first action was to appropriate $90,000,000 to be used as endowment grants to help strengthen instruction in the nation's 44 privately supported medical schools. As an initial disbursement under this appropriation, the Foundation made grants totaling $22,000,000 to these schools at the rate of $500,000 to each. For a period of 10 years the grants are to be held as invested endowment, with only the income to be expended for instructional purposes. Construction and research needs are specifically excluded from purposes of the grants. After the 10 year period has elapsed, the medical schools will be free to use the principal sum, as well as endowment income, for any academic purpose.

Entirely apart from the $90,000,000 endowment program is the $10,000,000 for a program of grants to assist the National Fund for Medical Education. Physicians are familiar with the National Fund, which was established in 1949 to campaign for funds, principally among corporations, to support medical education. These funds are given for current operating expenses and are distributed to each of the 81 accredited medical schools of the United States, public and private. Under the Foundation's appropriation, grants will be paid on a matching scale over a period of five to 10 years, the duration of the program depending upon the rate at which the National Fund develops additional support. The sliding formula of these grants is intended to give particular encouragement in the early years of the

plan to increasing the contributions of existing donors and to attracting new donors.

Of the Foundation's several programs, H. Rowan Gaither Jr., retiring president and now chairman of the Board of Trustees of the Foundation, said in his concluding review: "Education emerges as the major strand that ties together the purposes of almost our entire activity. . . . In the final analysis only the education of man—the acquisition of new knowledge, dissemination of accumulated knowledge and application of all knowledge—will remove man's own obstacles to social progress. Foundation philanthropy serves this end best when it serves as a radar detector, helping men and institutions to reach beyond man's sight and touch to detect the obstacles in his path."

OTHERS ARE SAYING

Courtesy

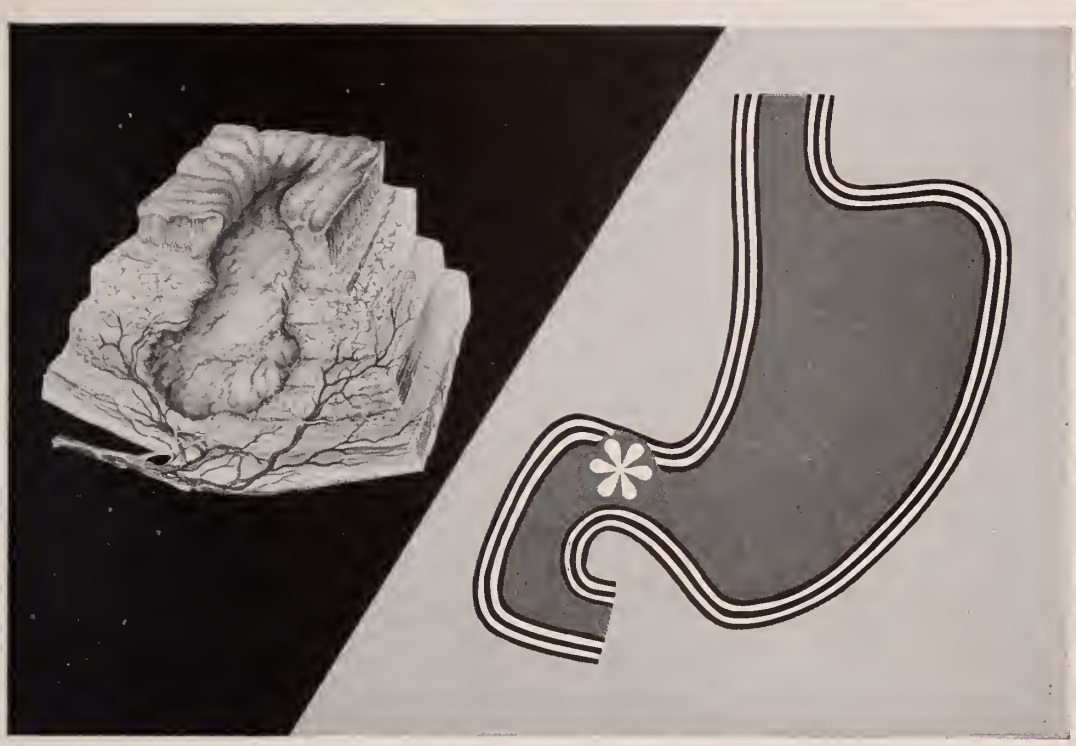
In these turbulent times of rapidly changing situations at home and abroad we are prone to allow the press of activity to cause us to overlook or forget the importance of a simple word composed of eight letters—*Courtesy*. Courtesy is in reality a habit. It is something which is in one way or another bred into us by our parents and teachers in the formative years of our childhood and youth, and is a quality essential for success in later years. It is a pattern which cannot be acquired overnight, for no good habit can be developed within the matter of a few hours. It must be exercised over *and* over, day after day, in order to become a natural, spontaneous, genuine attribute so necessary for success in dealing with other people. If we pause to consider the Golden Rule, "Do unto others as ye would they should do unto you," the need for courtesy is obvious. All of us would prefer to be treated in a courteous manner by others, and in turn it stands to reason that others would prefer that we be courteous to them.

In the esteemed profession of Medicine nothing is more important than the exhibition of courtesy towards our patients and all those with whom we come into contact. We are not judged by our knowledge of medicine alone. Conversely, there is much to indicate that the laity not only expects but demands far more from the physician than a simple prescription for medication. Patients frequently want someone in which to confide their troubles. Others may require sympathy. Some have developed a morbid and overwhelming fear of disease, be it imaginary or real, and need reassurance. Each patient feels that his individual problem is the most important thing in the world, and justly so. He would not consult the doctor if his problem were not important to him. He not infrequently comes to the office with the feeling that only the doctor can help him, so it behooves the physician to utilize every facility at his command to justify the faith of his patient.

If the doctor is courteous enough to listen attentively to the story of the patient, he has made the first and probably most important step in gaining the confidence of that person. There are times when the patient's story will seem totally unrelated to disease, but if the physician listens closely and appears genuinely interested, the patient will feel at ease and it will be much easier to establish proper rapport with him. Some have had the unpleasant experience of hearing a patient say, "Doctor John Doe may be a good doctor, but he tries to rush too much and won't listen to me. His main thought seems to be to get me out of his office as soon as he can, and I am never going to him again." This connotes an unhappy situation for it means that Dr. Doe either was too busy or forgot to be courteous, consequently losing a patient, plus the fact that the patient will ultimately transfer some of his resentment of the particular physician in question to the medical profession as a whole, either consciously or subconsciously. A prominent and well-respected pediatrician practicing in Chicago once made the statement, "I don't want to be known as the *busiest* doctor in town. I would much rather be known as the *best* doctor in town." He qualified these words by explaining that a satisfied patient usually feels that his doctor is "the best doctor in town." He further propounded that in order to have a practice composed of satisfied patients a physican must be courteous, patient, and spend sufficient time with them. Courtesy is one of the most solid stepping stones in our quest for good public relations, and its importance must be kept in the forefront at all times.

It has become apparent in recent years that increasing stress is being placed upon courtesy in public relations. Many large organizations have signs saying, "Courtesy is Contagious" displayed at conspicuous places for the benefit of their employees and clientele. There is great truth in this slogan, for it is difficult for the majority of people to remain intractable in the face of an approach whose structure is sagely based upon un-

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Pro-Banthine® Relieves Pain, Accelerates Peptic Ulcer Healing

The efficiency of Pro-Banthine (brand of propantheline bromide) in inhibiting the chemical substance which mediates parasympathetic gastric activity explains the success of the drug in ulcer therapy. Pro-Banthine blocks acetylcholine at both the ganglia and parasympathetic effector sites. This dual action controls excess neural stimulation of both gastric secretion and motility.

The therapeutic benefits of this anticholinergic blockade consist, as many clinical investigators have noted, in prompt relief of ulcer pain and pronounced acceleration of ulcer healing.

The suggested initial dosage is one 15-mg. tablet with meals and two tablets at bedtime. Two or more tablets four times a day may be indicated in severe manifestations. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

faltering courtesy. It often acts as a balm which may be spread to sooth even the most ruffled feelings.

These same principles are also applicable to the receptionist, nurse, aide, or technician in the office of the doctor. All employees should be repeatedly impressed with the urgency for the use of courtesy in dealing with the public This is particularly true of the person assigned to answer the office phone. The patient calling in for an appointment or to talk to the doctor is frequently very worried or upset, and may be difficult to manage. It is here that a little courtesy, a kind word or two, and a little patience on the part of the person taking the call will so often pay great dividends in the form of satisfactory doctor-patient relationships. The attitude of the office staff frequently has much to do with the success of the treatment. Hippocrates, the acknowledged "Father of Medicine," said in his Oath, "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone." All physicians are sworn to uphold the principles of this great vow, and the place of courtesy in this regimen must be recognized. Great harm can be done by failing to do so. After all, a satisfied patient is the physician's best and only means of advertisement.

R. C. P.
Monthly Bulletin
Duval County Medical Society
November 1956

Proceedings
Eighty-Third Annual Meeting
Florida Medical Association

The complete proceedings of the Eighty-Third Annual Meeting of the Florida Medical Association are published in this issue of The Journal. The scientific papers delivered during the meeting are scheduled to be published in subsequent issues.

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State Hospitals, correctional facilities and veterans home. No written examination. Interview only . . . Three salary groups:

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Salary increases being considered effective July 1957
U.S. citizenship and possession of, or eligibility for California license required.

Write:
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NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Ahmann, Helen M., Deerfield Beach
Bailey, Jesse K., Miami
Blumenfeld, Irving H., Miami
Broadaway, Rufus, Miami
Caster, Milton P., Hollywood
Chenault, John W. (Col.), Bradenton
Chew, William, Orlando
Costanza, Louis C., Jacksonville
Crumbley, James J. Jr., Tampa
Cunningham, George A. III, West Palm Beach
Daurelle, George P., Miami
Douglas, Robert A., Homestead
Foertsch, Frederick E. Jr., Winter Park
Foster, L. Paul, Orlando
Fuerst, Howard J., Hollywood
Gastring, Joseph B., Valparaiso
Getz, Alvin M., North Miami Beach
Goodman, Julian J., West Palm Beach
Gowin, Thomas S., South Miami
Grosz, Eugene, Coral Gables
Harris, Robert D. Jr., St. Augustine
Koval, John M., South Miami
Lancaster, James W., Coral Gables
Lauth, Edward J. Jr., North Miami
McConnell, Bright Jr., Orlando
Maxwell, William, Miami Beach
Melvin, Hiram M., Milton
Millard, David R. Jr., Miami
Morris, Douglas C., Miami
Mullen, Sanford A., Jacksonville
Nelson, Harry C. Jr., Miami
Nesbitt, James III, Miami
Nogueiras, Humberto M., Miami
Ortega, Gimel, Miami
Page, William G., Orlando
Pearl, Morton, Miami Beach
Reiff, Max H., Hialeah
Sheehy, Paul L., Tampa
Simonson, Melvin, Coral Gables
Steinmetz, Rodney D., Tampa
Tate, Charles F. Jr., Miami
Terragni, Manlio, Miami
Thompson, William W., Fort Walton Beach
Valentine, E. Henry Jr., Miami
Vanden Bosch, Jay H., Coral Gables
Wright, Henry L. Jr., Tampa
Zaydon, Thomas J., Coconut Grove

Current Practices in Dietary Management of

Infant Allergies

Infants are not born hypersensitive but may develop hypersensitivity to foodstuffs shortly after birth. The earliest sensitizations are likely to be to milk, wheat, eggs and orange juice, with which contact is established early in life. Heredity is usually a dominant factor in the tendency of infants to develop allergy. Infants with a family history of both paternal and maternal allergy tend to develop clinical symptoms earlier than those with unilateral inheritance. Both the allergen and the symptom in the infant may be different from those of the father or mother.

Allergic disorders of infants include gastrointestinal disturbances, infantile eczema, urticaria and asthma. Gastrointestinal allergy may be manifested by vomiting, colicky abdominal pain and diarrhea. Allergic dermatitis may be evidenced by wheal-like cutaneous reactions which may develop into exudative lesions over the scalp, face and body. A systemic food hypersensitivity may produce an asthmatic response manifested by dyspnea and wheezing, although infection is usually associated with this type of response.

Common treatments include avoidance of the allergen, desensitization, antihistaminics and, in the presence of infection, antibiotics. Infants sensitive to the proteins of cow's milk whey may be fed human, goat or mare's milk reinforced with KARO® Syrup. Casein-sensitive infants may be offered soybean milk or amino acid mixtures reinforced with KARO Syrup.

The same problems of infant feeding recur from generation to generation, but solutions may differ with each era. The carbohydrate requirement for all infants is as completely fulfilled by KARO Syrup today as a generation ago. Whatever the type of milk adapted to the individual infant, KARO Syrup may be added confidently because it is a balanced mixture of low molecular weight sugars, readily miscible, well tolerated, palliative, hypo-allergenic, resistant to fermentation in the intestine, easily digestible, readily absorbed and non-laxative. KARO is readily available in all food stores.

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WHOLE GOAT'S MILK FORMULAS

Age Months	Fluid Milk Fluid Oz.	Water Oz.	KARO Tbsp.	Each Feeding Oz.	No. of Feedings in 24 Hrs.	Total Calories
Birth	10	10	2	3	6	320
1	12	13	2½	4	6	390
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760
7	28	11	3	7½	5	740
8	30	11	2½	8	5	750
10	32	9	2	8	5	760

EVAPORATED GOAT'S MILK FORMULAS

Age Months	Weight Lbs.	Evap. Goat's Milk Oz.	Water Oz.	KARO Tbsp.	Each Feeding Oz.	No. of Feedings in 24 Hrs.	Total Calories
Birth	7	6	12	1	3	6	290
1	8	8	16	2	4	6	395
2	10	9	14	3	4½	5	520
3	12	10	15	3½	5	5	590
4	14	12	18	4	6	5	695
5	16	12	21	4	6½	5	695
6	17	13	22	4	7	5	730
7	18	14	21	3	7	5	710
8	19	15	20	2	7	5	690
10	21	16	16	1	8	4	730

LIQUID SOY MILK FORMULAS

Age Months	Evap. Milk Fluid Oz.	Water Oz.	KARO Tbsp.	Each Feeding Oz.	No. of Feedings in 24 Hrs.	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	4	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	768
7	14	21	3	7	5	796
8	15	20	2	7	5	780
10	16	16	1	8	4	764

DRIED SOY MILK FORMULAS

Age Months	Dry Milk	Water Oz.	KARO Tbsp.	Each Feeding Oz.	No. of Feedings in 24 Hrs.	Total Calories
Birth	6	20	2	3	7	360
1	8	22	2	4	6	440
2	9	24	2½	4	6	510
3	10	29	3	6	5	590
4	12	33	3½	7	5	690
5	13	33	3½	7	5	730
6	14	33	3½	7	5	740
7	14	33	2½	7	5	710
8	15	33	2	7	5	720
10	15	33	2	8	4	720



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STATE NEWS ITEMS

The annual meeting of the Southeastern Allergy Association will be held November 1-2 in the Fort Sumter Hotel at Charleston, S. C., according to announcement by Dr. Clarence Bernstein, of Orlando, President. Reservations for the meeting should be made early with Dr. Katharine B. MacInnis, Secretary-Treasurer, 818 Albion Road, Columbia, S. C.

Dr. C. Ashley Bird of Jacksonville has returned from St. Louis, Mo., where he was certified a diplomat by the American Board of Neurological Surgeons.

Dr. Ralph W. Jack of Miami was elected president of the Continental Gynecologic Society during the recent meeting held at Havana, Cuba, and in Miami.

Dr. J. M. Ingram Jr. of Tampa was one of the principal speakers on the program presented at Havana. The title of his address was "Vaginal Hysterectomy After Pelvic Surgery."

Dr. James H. Ferguson of Miami, Professor of Obstetrics and Gynecology at the University of Miami School of Medicine, arranged and presided at the program presented for the Society at Miami in Jackson Memorial Hospital.

Dr. Jack acted as host and chairman of the committee on local arrangements for the combined meeting. Vancouver, British Columbia was selected as the place for the next meeting.

Dr. Alvyn W. White of Pensacola has been elected president of the recently organized Escambia Pediatric Society. Serving with Dr. White will be Dr. Joseph L. Rubel as vice president and Dr. Reed Bell as secretary-treasurer. Regular meetings are to be held every Tuesday which is the fifth Tuesday in the month.

Dr. Meyer B. Marks of Miami Beach has been certified in pediatric allergy by the Amercan Board of Pediatrics.

Dr. I. Leo Fishbein of Miami Beach has returned from Chicago where he attended a meeting of the American Psychiatric Association.

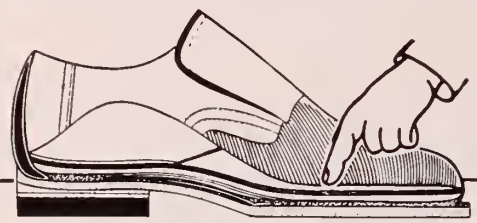
The Second Annual Alpha Kappa Kappa Lectureship sponsored by the Beta Chi Chapter at the University of Miami School of Medicine was presented to the students, faculty and staff at the Jackson Memorial Hospital the middle of May.

The lecture this year was entitled "Some Practical Aspects of Nutrition" and was presented by Dr. Garfield G. Duncan of Philadelphia. Dr. Duncan is Clinical Professor of Medicine at Jefferson Medical College and is head of the Department of Nutrition and Metabolism at the Pennsylvania Hospital in Philadelphia.

A Postgraduate Course in Pediatric Allergy has been announced by the Division of Graduate Studies, Department of Graduate Pediatrics, of the New York Medical College. The course will be held from November 6, 1957 to May 28, 1958 under the direction of Dr. Bret Ratner, Professor of Clinical Pediatrics and Associate Professor of Immunology. The fee is $300. Applicants for the course must be certified in pediatrics or have the requirements for certification. A limited number of allergists practicing with adults may also apply. Information may be obtained from: Office of the Dean, New York Medical College, Fifth Avenue at 106th Street, New York 29.

(State News Items are continued on page 94)

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(Continued from page 92)

Drs. Alvan G. Foraker, Wilbur C. Sumner and Sam W. Denham of Jacksonville have received a grant of $5,708 from the National Cancer Institute to be used to equip and furnish a special research laboratory for cancer and other research.

Dr. Louis J. Polskin of Lakeland addressed the Subsection of the American Chemical Society meeting at the Lake Alfred Citrus Experiment Station the middle of May on the biochemistry of the "Mental Molecules." Later, Dr. Polskin spoke to the science classes of Kathleen High School on the subject "Science as a Career."

The American College of Gastroenterology announces that its annual course in postgraduate gastroenterology will be given at The Somerset in Boston, Mass., October 24-26.

The course will again be under the direction and chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery, University of Minnesota Medical School, and Dr. I. Snapper, Director of Medical Education, Beth-El Hospital, Brooklyn.

For information and enrolment write to the American College of Gastroenterology, 33 West 60th St., New York 23.

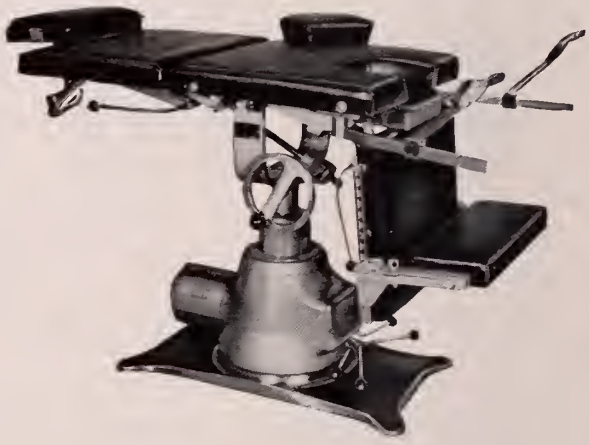
Dr. J. Ernest Ayre of Miami has been elected president of the Pan American Cancer Cytology Society which was formed during the First Pan American Cancer Cytology Congress held at Miami.

The Seventh Congress of the Pan-Pacific Surgical Association is scheduled for November 14-22 at Honolulu, Hawaii. Information on the Congress may be obtained from Dr. F. J. Pinkerton, Director General, Pan-Pacific Surgical Association, Room 230, Young Building, Honolulu.

Dr. Sherman B. Forbes of Tampa attended the Interim Congress of the Pan-American Association of Ophthalmology and the 1957 Conference of the National Society for the Prevention of Blindness held April 7-10 in the Hotel Statler, New York City.

Dr. Frederick K. Herpel of West Palm Beach, a past president of the Florida Medical Association, left for California the last of May and plans to be away for about two months. His itinerary includes numerous clinics and hospitals.

The Ritter Examining and Treatment Table enables the physician to treat more patients, more thoroughly with less effort in less time

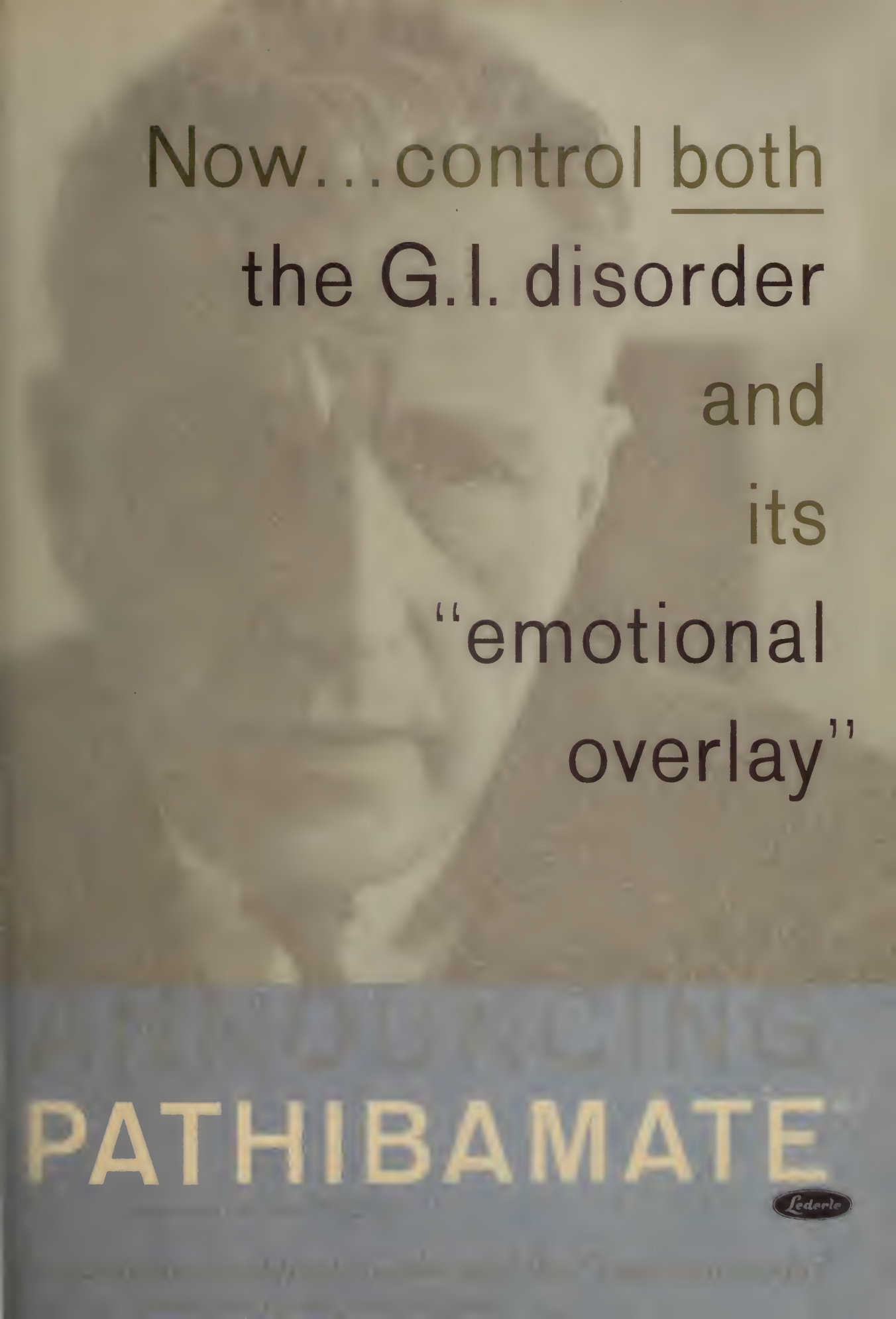


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the G.I. disorder
and
its
"emotional
overlay"
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(Continued from page 92)

Drs. Alvan L. Barker, Wilbur C. Sumner and [illegible] Jacksonville have received a grant of $[illegible] from the National Cancer Institute to be used to equip and furnish a special research laboratory for cancer and other research

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"overlay"

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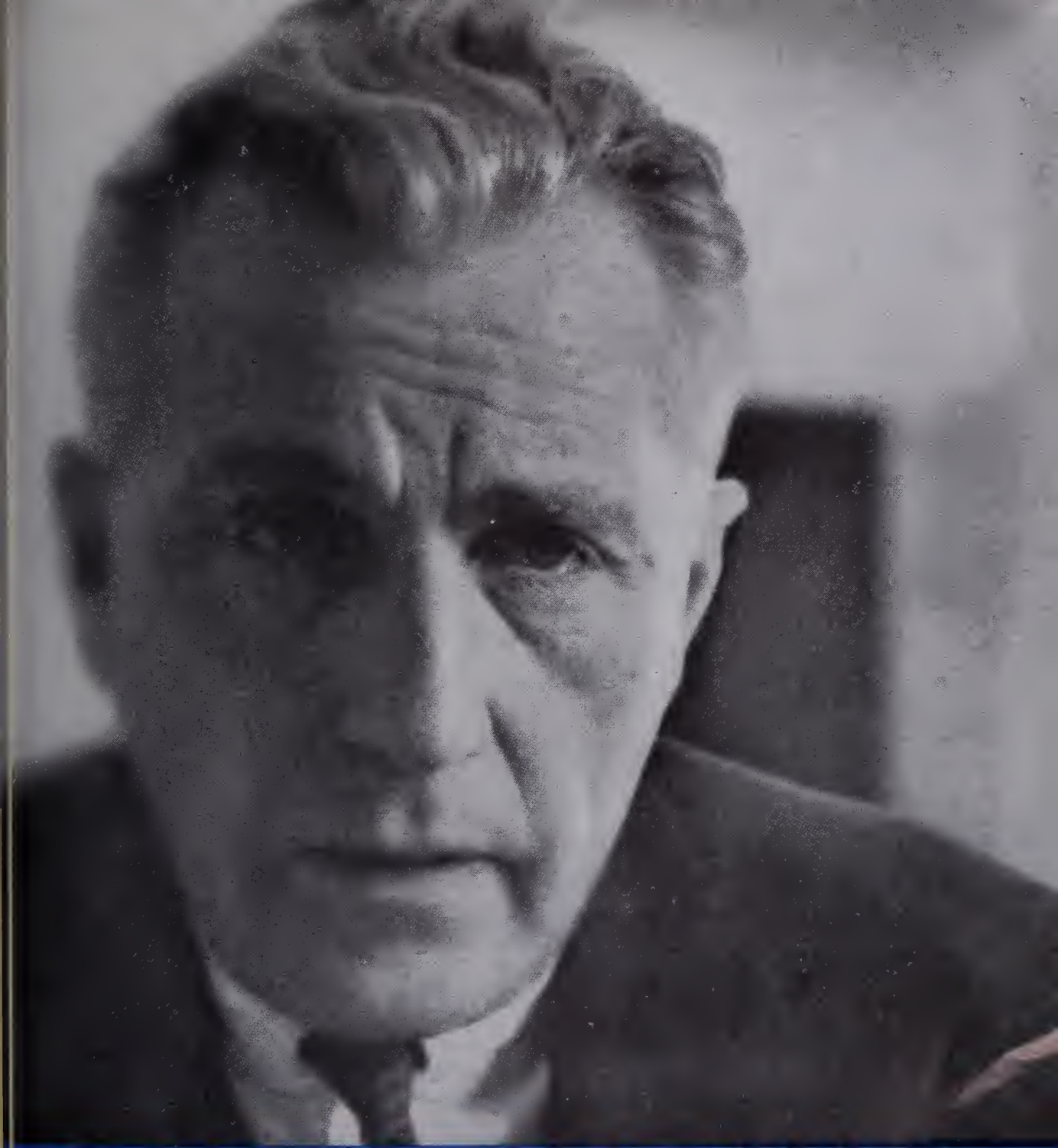
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Now...with **PATHIBAMATE**...*you can control disorders of the digestive tract and the "emotional overlay" so often associated with their origin and perpetuation...without fear of barbiturate loginess, hangover or addiction. Among the conditions which have shown dramatic response to* **PATHIBAMATE** *therapy:*

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• "I find it easy to keep patients using the drug continuously and faithfully. I feel sure this is due to the desirable effect of the tranquilizing drug."[5]

• "The results in several people who were previously on belladonna-phenobarbital preparations are particularly interesting. Several people volunteered that they felt a great deal better on the present medication and noted less of the loginess associated with barbiturate administration."[6]

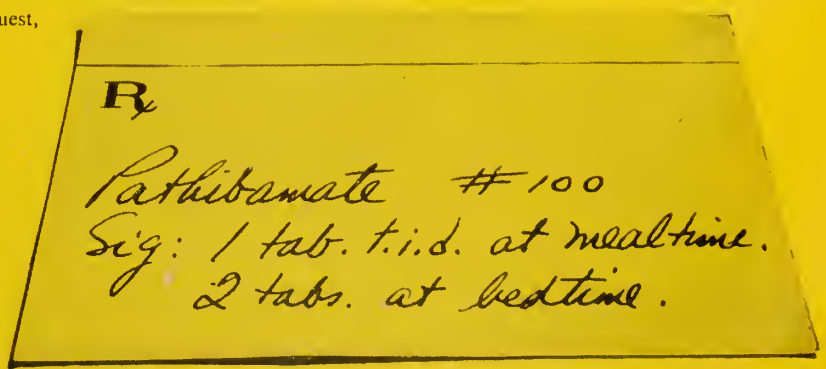
• PATHIBAMATE..."will favorably influence a majority of subjects suffering from various forms of gastrointestinal neurosis in which spasmodic manifestations and nervous tension are major clinical symptoms."[7]

• "In the patients with functional disturbances of the colon with a high emotional overlay, this has been to date a most effective drug."[5]

ferences: 1. Borrus, J. C.: *M. Clin. North America,* ress, 1957. 2. Gillette, H. E.: *Internat. Rec. Med. & G. P.* . 169.453, 1956. 3. Pennington, V. M.: *J.A.M.A.,* ress, 1957. 4. Cayer, D.: Prolonged Anticholinergic rapy of Duodenal Ulcer. Am. J. Dig. Dis. 1:301-309 y) 1956. 5. McGlone, F. B.: Personal Communication to lerle Laboratories. 6. Texter, E. C., Jr.: Personal nmunication to Lederle Laboratories. 7. Bauer, H. G. a McGavack, T. H.: Personal Communication ederle Laboratories.

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COMPONENT SOCIETY NOTES

Brevard

Dr. Samuel S. Wright, of Melbourne, and Dr. Lewis A. Bean, of Cocoa, were principal speakers at the May meeting of the Brevard County Medical Society held at the Rockledge Medical Center. Dr. Wright discussed the role of antibiotics in the treatment of pulmonary infections, and Dr. Bean's address was on certain physiological problems of pulmonary disease.

Collier

The Collier County Medical Society has paid 100 per cent of its state dues for 1957.

Columbia

The Columbia County Medical Society has paid 100 per cent of its state dues for 1957.

Duval

A showing of the film "The Medical Witness" and a discussion of the film by Judge Claude Ogilvie, of Jacksonville, were features of the June meeting of the Duval County Medical Society. Members of the Jacksonville Bar Association were invited guests.

Franklin-Gulf

The Franklin-Gulf County Medical Society has paid 100 per cent of its state dues for 1957.

Hillsborough

Dr. Zack Russ Jr., of Tampa, was principal speaker for the June meeting of the Hillsborough County Medical Association. Dr. Russ discussed "Current Trends in Electroshock Therapy."

Lake

Dr. John Riepenhoft, of the Ohio State University College of Medicine at Columbus, addressed the members of the Lake County Medical Society at their May meeting. His subject was convulsions as related to the practice of pediatrics.

Manatee

The Manatee County Medical Society has paid 100 per cent of its state dues for 1957.

Monroe

The Monroe County Medical Society has paid 100 per cent of its state dues for 1957.

Nassau

The Nassau County Medical Society has paid 100 per cent of its state dues for 1957

(Continued on page 100)

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. . . because Rauwiloid's *nonsoporific* sedative action relieves anxiety in a long list of unrelated diseases not necessarily associated with hypertension . . . without masking of symptoms . . . without impairing intellectual or psychomotor efficiency.

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Riker LOS ANGELES

(Continued from page 98)

Pinellas

Dr. Walter H. Bailey, of St. Petersburg, discussed "Use and Misuse of Tranquilizers" at the June meeting of the Pinellas County Medical Society held at the Fort Harrison Hotel in Clearwater.

Suwannee-Hamilton-Lafayette

The Suwannee-Hamilton-Lafayette County Medical Society has paid 100 per cent of its state dues for 1957.

St. Johns

The St. Johns County Medical Society has paid 100 per cent of its state dues for 1957.

Washington-Holmes

The Washington-Holmes County Medical Society has paid 100 per cent of its state dues for 1957.

Medical Officers Returned

Dr. Charles A. Schwarz, who entered military service on July 1, 1954, was released from active duty on Aug. 5, 1956, with the rank of major, U. S. Army. His address is 1005 96th Street, Miami Beach.

Dr. Russell V. Douglas, who entered military service on May 8, 1955, was released from active duty on May 7, 1957, with the rank of major, U. S. Army. His address is 1500 Kuhl Avenue, Orlando.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Edward S. Lundell of Jacksonville announce the birth of twin sons, Ronald and Donald, on April 19, 1957.

Deaths—Member

Smith, James Alonzo, Sanford.....February 19, 1957
Trousdale, Theodore M., Sarasota.....April 16,1957

Deaths—Other Doctors

Young, Robert U., Tampa.....April 11, 1957
Blum, Leo J. Jr., Warner Robins, Ga.....Dec. 8, 1957
Fox, John W., St. Petersburg.....Feb. 7, 1957
McClure, Herbert A., Vernon, Ala.....March 21, 1957
Martin, Orel F., Coral Gables.....January 7, 1957
Sparks, Proctor, St. Petersburg.....January 16, 1957
Thompson, John James,
St. Petersburg.....January 2, 1957
Twomey, George Watson,
Fort Myers.....November 25, 1956

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INTERNIST WANTED: Established certified internist desires associate. Florida license, certified or board eligible. Give full background in first letter. Write 69-224, P. O. Box 2411, Jacksonville, Fla.

OBSTETRICIAN-GYNECOLOGIST: Completing residency July 1957. Florida license. Family. Age 30. Category IV. Desires group practice or association. Write 69-225, P. O. Box 2411, Jacksonville, Fla.

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LOCUM TENENS: July 1, 1957 to January 1, 1958. General Practitioner to associate with same. Suburban Jacksonville. To future association as agreed. Write 69-229, P.O. Box 2411, Jacksonville, Fla.

POSITION WANTED: British physician (Hungarian born). Permanent resident USA first papers, 1954. Wishes position in Florida pending admission State Board. Experienced in medicine, surgery, gynecology, research, medical journalism and languages. Write P. O. Box 591, Miami, Fla.

WANTED: Specialist in Obstetrics and Gynecology with Florida license to associate with group in Dade-Broward area. Board man preferred. Write age, training, chronology of medical experience, references. Write 69-230, P. O. Box 2411, Jacksonville, Fla.

WANTED: Pediatrician or General Practitioner with special training in pediatrics to associate with group in Dade-Broward area. Florida license necessary. Write age, training, chronology of medical experience, references. Write 69-231, P. O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner to take over practice in well-populated community 25 miles north of Tampa. Hospital located nine miles away; open staff. One other physician in community. Office space under existing lease available August 1. Write 69-232, P. O. Box 2411, Jacksonville, Fla.

OBITUARIES

Louis J. Garcia

Dr. Louis J. Garcia of Tampa died suddenly following a heart attack on Dec. 23, 1956. He was 52 years of age.

A native of Cuba, Dr. Garcia was born in Havana on Aug. 19, 1905, and received his primary schooling in a Catholic school in that city. At the age of 12 years, he was sent to the United States to attend high school and college in Belmont, N. C. He received his professional training at Georgetown University School of Medicine in Washington, D. C., where he was awarded the degree of Doctor of Medicine in 1931. After serving an internship in Georgetown University

(Continued on page 104)

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the tranquilizer *Miltown* in "Mil*path*" controls the psychogenic element in G. I. disturbances. (Miltown does not produce barbiturate loginess or hangover.)

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At the peripheral level

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G.I. symptoms of anxiety states

prescribe:
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tridihexethyl iodide 25 mg. (3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethiodide)
U. S. Patent 2,698,325.

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(Continued from page 102)

Hospital, he was granted a fellowship there in internal medicine and later completed a residency at the Tampa Municipal Hospital in Tampa.

In 1935, Dr. Garcia was appointed City Physician, Health Department of Tampa, and actively campaigned in the control and treatment of tuberculosis. He pursued his studies in this field and in 1938 took a course given by Dr. Corillos on tuberculosis at Seaview and Bellevue Hospitals in New York. In 1939, when the Tuberculosis Hospital for Children was opened in Tampa, Dr. Garcia took charge of this institution.

During World War II, Dr. Garcia served in the United States Army. He was commissioned a captain in 1942 and was separated from military service in 1946 with the rank of major.

Upon his return to Tampa, Dr. Garcia resumed his post with the Hillsborough County Health Department and re-established his private practice. Locally, he served on the staffs of St. Joseph's Hospital, Tampa Municipal Hospital, Tampa Municipal Negro Hospital and the Centro Asturiano Hospital. He engaged in numerous civic activities. As a music lover, he helped to foster the Little Theatre, the Symphony Orchestra, the Civic Ballet and other organizations. He was treasurer of the Tampa Civic Ballet Association.

Dr. Garcia was a member of the Hillsborough County Medical Association, the Florida Medical Association, the American Medical Association, the Pan American Medical Association and the American College of Chest Physicians. He also held membership in the American Trudeau Society and the Florida Trudeau Society.

Surviving are the widow, Mrs. Mary Josephine Garcia; two daughters, Louisa and Sylvia Garcia, of Tampa; the mother, Mrs. Mercedes Garcia, of Cuba; three sisters, Mrs. Gloria Alfaro and Mrs. Mercedes Garcia, of Panama, and Mrs Margot Ferrer, of Cuba; and two brothers, Jose Antonio and Alfredo Garcia, of Tampa.

Charles William Larrabee

Dr. Charles William Larrabee of Bradenton died at his home on the grounds of the Bradenton General Hospital on April 13, 1957, after a long illness. He was 86 years of age.

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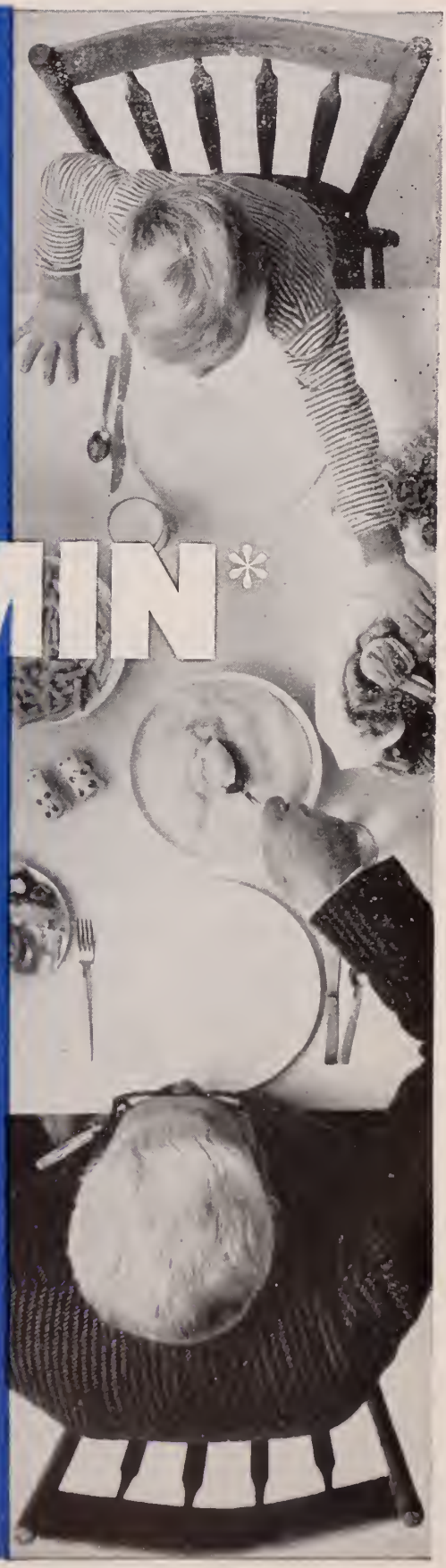
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Born in 1870, Dr. Larrabee was a native of Bath, Maine, and attended schools there. He received his medical training at the Maryland College of Eclectic Medicine and Surgery in Baltimore, where he was awarded the degree of Doctor of Medicine in 1913.

Dr. Larrabee practiced in Boston and Gainesville, Ga., before locating in Florida. In 1921, he and his wife, Mrs. Dovie Collins Larrabee, came to Bradenton and established Larrabee Hospital, later named Bradenton General Hospital, which Mrs. Larrabee still directs. This institution was the first hospital in Manatee County. As a charter member of the Bradenton Elks Lodge and of the Art League of Manatee County, and as a member of the Bradenton Chamber of Commerce this pioneer physician and surgeon was prominently identified with many civic undertakings. He was a founder of the Bradenton Yacht Club and was a leader in conducting many regattas and other boating events. A past president of the former Bradenton Optimist Club, he was also president of the State of Maine Club during its entire existence. He was of the Congregationalist faith.

For many years, Dr. Larrabee maintained a home, Larrahurst, at Devil's Elbow, a bend on the upper Manatee River. During that period of his life, the grounds and facilities were open to the many friends of Dr. and Mrs. Larrabee and to the general public for picnics and river sports.

Locally, Dr. Larrabee was a member of the Manatee County Medical Society. For 31 years he had been a member of the Florida Medical Association, holding honorary status in recent years. Other professional affiliations included membership in the Southern Medical Association and honorary membership in the American Medical Association.

In addition to the widow, Dr. Larrabee is survived by a daughter, Mrs. Raymond L. Bond Sr., of Jefferson, Maine; a sister, Mrs. Clara Marson, of Booth Bay Harbor, Maine; a brother, Albert Larrabee, of Auburn, Maine; one grandson and six greatgrandchildren.

BOOKS RECEIVED

Vital Statistics of the United States 1954. *Volume I. Introduction and Summary Tables; Tables for Alaska, Hawaii, Puerto Rico, and Virgin Islands; Marriage, Divorce, Natality, Fetal Mortality and Infant Mortality Data.* U. S. Department of Health, Education, and Welfare, Public Health Service, National Office of Vital Statistics. Prepared under the supervision of Halbert L. Dunn, M.D., Chief, National Office of Vital Statistics. Pp. 357. Price, $3.75. Washington, D. C., United States Government Printing Office, 1956.



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This is one of two volumes presenting final vital statistics for the United States, its Territories, and two possessions for the year 1954. Their subject matter consists of vital events that occurred in these areas during the year — marriages, divorces, births, fetal deaths, infant deaths, and deaths among the general population. The contents of the present volume are described in the title. The second volume of the annual report will contain mortality data for the United States and each state.

Vital Statistics of the United States 1954. *Volume II. Mortality Data.* U. S. Department of Health, Education, and Welfare, Public Health Service, National Office of Vital Statistics. Prepared under the supervision of Halbert L. Dunn, M.D., Chief, National Office of Vital Statistics. Pp. 505. Price, $4.00. Washington, D. C., United States Government Printing Office, 1956.

This is the second of two volumes presenting final vital statistics for the United States, its Territories, and two possessions for the year 1954. It contains mortality data for the United States and each state.

A Doctor's Marital Guide for Patients. By Bernard R. Greenblat, B.S., M.D. Pp. 88. Price, $1.50. Chicago, The Budlong Press, 1956.

This nontechnical and well illustrated book is extremely practical in that it clearly presents the best known information about sex and marriage which patients frequently find hard to discuss with anyone but their doctor. It is written for those who are married or are about to be married and offers common sense advice for both husband and wife to help them attain a normal and adjusted sex life. Available only through physicians, it is printed in two editions: Regular and Catholic. The latter eliminates the chapter on birth control and instead discusses the Catholic viewpoint toward family spacing and related matters. Sample copies will be mailed to physicians upon request.

Surgery in World War II. Volume II. General Surgery. Editor in Chief, Colonel John Boyd Coates, Jr., MC; Editor for General Surgery, Michael E. DeBakey, M. D. Pp. 417. Washington, D. C., Office of the Surgeon General, Department of the Army, 1955.

Volume II on general surgery (volume I will appear later) is set apart from other volumes of the history of the Medical Department of the United States Army in World War II by several special considerations. It is a story not only of surgery performed in forward Army medical units, but of extremely urgent surgery. It also records the performance of an auxiliary surgical group, and as such is typical of the outstanding work done in all theaters of operations by the medical officers assigned to similar units, as well as by medical officers organically assigned to frontline hospitals in which surgical teams from auxiliary surgical groups were employed.

The 3,154 abdominal injuries upon which this story is chiefly based were all the result of the violence of war, and undoubtedly comprise the largest series to be analyzed in such detail. The policy of prompt surgical intervention in abdominal injuries was made practical and possible because of another concept new in World War II, the practice of preoperative resuscitation, which is also described in this volume. Other important departures from previous medicomilitary practices include the management of wounds of the rectum and large bowel by colostomy with or without exteriorization of the damaged segment, surgical treatment of wounds of the liver, and the transdiaphragmatic approach to thoracoabdominal wounds.

This book should have particular interest for military and civilian surgeons and also medical students who anticipate military service. It is not alone a record of past events but also a source of potential usefulness at this time and for the future in a world not yet at peace.



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Surgery in World War II. Orthopedic Surgery in the European Theater of Operations. Editor in Chief, Colonel John Boyd Coates, Jr., MC; Editor for Orthopedic Surgery, Mather Cleveland, M.D. Pp. 397. Washington, D. C., Office of the Surgeon General, Department of the Army, 1956.

This is the first of three planned volumes on orthopedic surgery to be included in the history of the United States Army Medical Department in World War II. In that war the European theater was the largest single theater. Casualties were heavy, and, as in all theaters, battle injuries of the extremities, including bones and joints, comprised the largest single group, approximately two thirds of the 381,350 wounded and injured in action in Europe.

The orthopedic care of this enormous number of wounded was a task of the first magnitude, brilliantly planned and accomplished. This record, therefore, of that remarkable feat will be of great interest to all medical officers who served in this country and overseas, whether they have returned to civilian life or are still in the Army. It will also be of interest to the medical officers who served in Korea and will be a source of information and inspiration to students now in medical school who face a term of service after graduation in one of the medical services of the Armed Forces.

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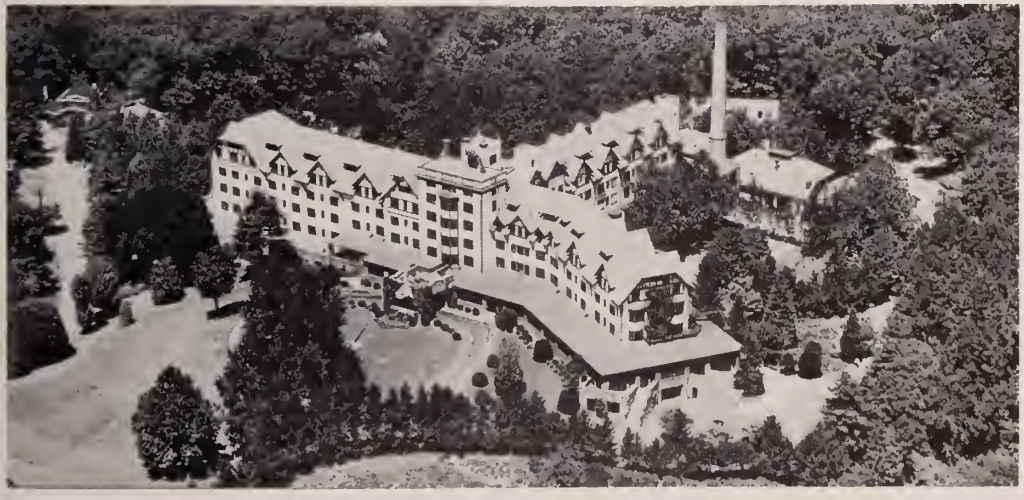
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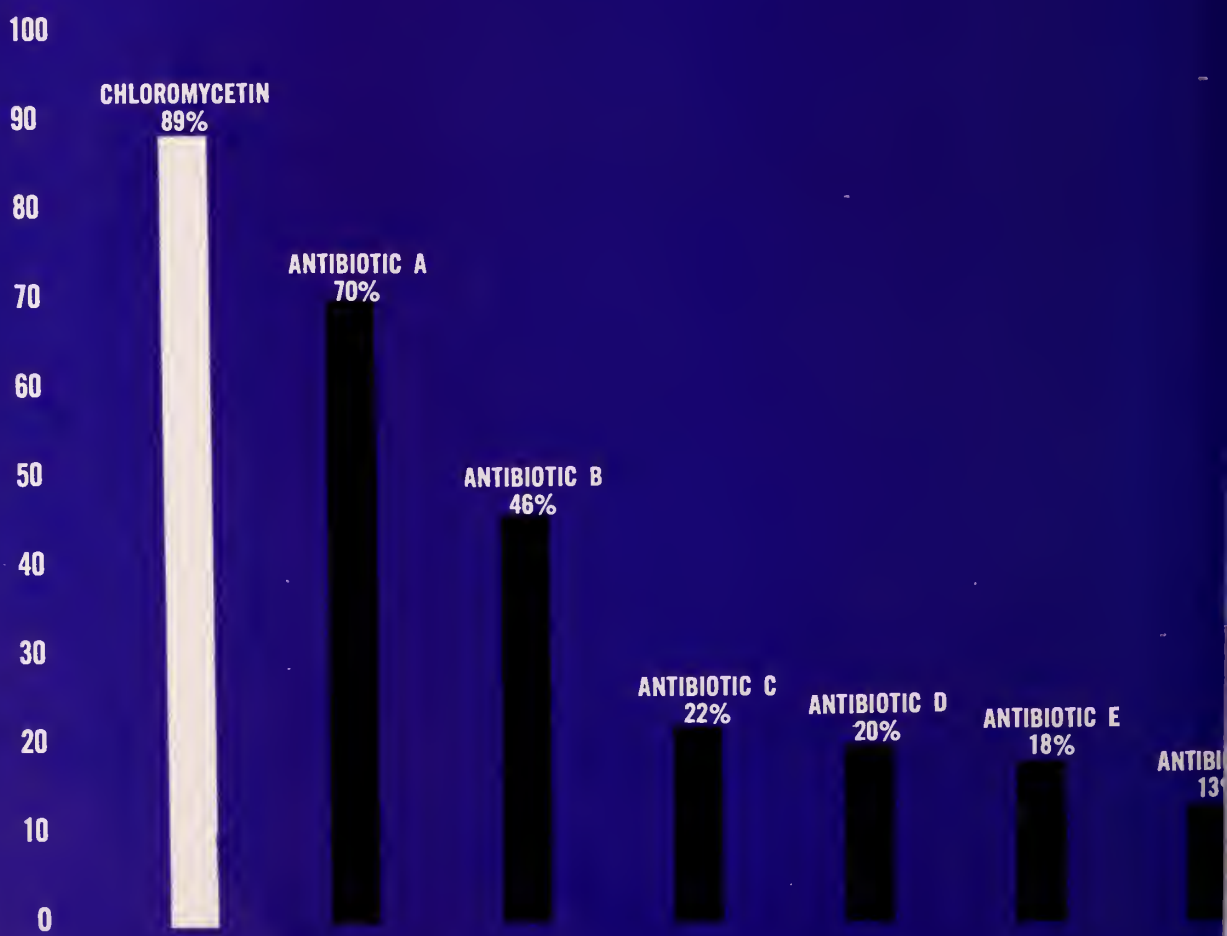
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Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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1. Bodkin, L. G., and Ferguson, E. A., Jr.: Am. J. Digest. Dis. 18:59 (Feb.) 1951. 2. Arthur, R. P., and Shelley, W. B.: J. Invest. Derm. 25:341 (Nov.) 1955. 3. McGivney, J.: Texas J. Med. 47:770 (Nov.) 1951.

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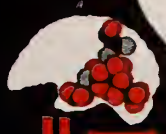
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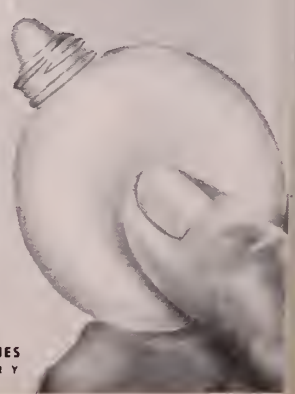
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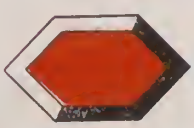
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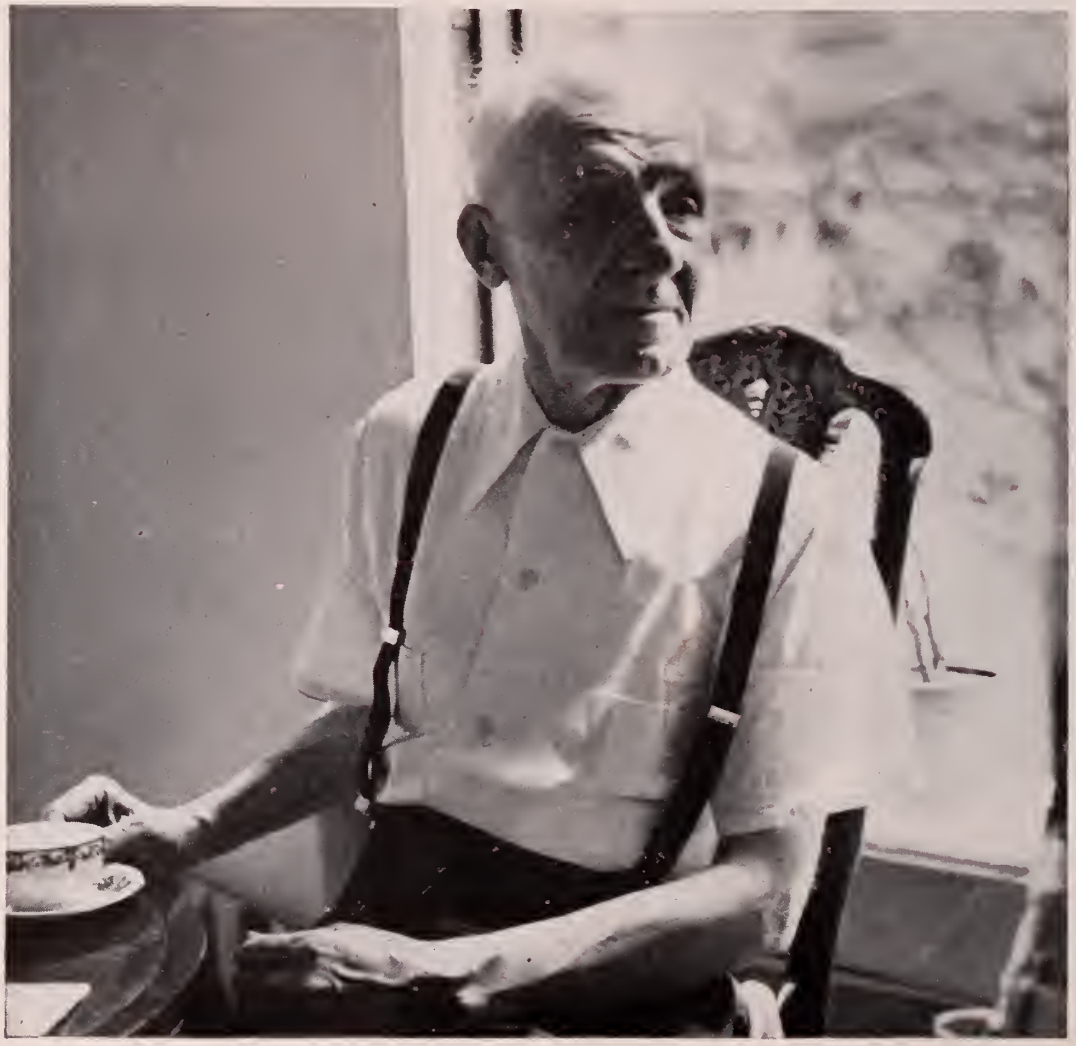
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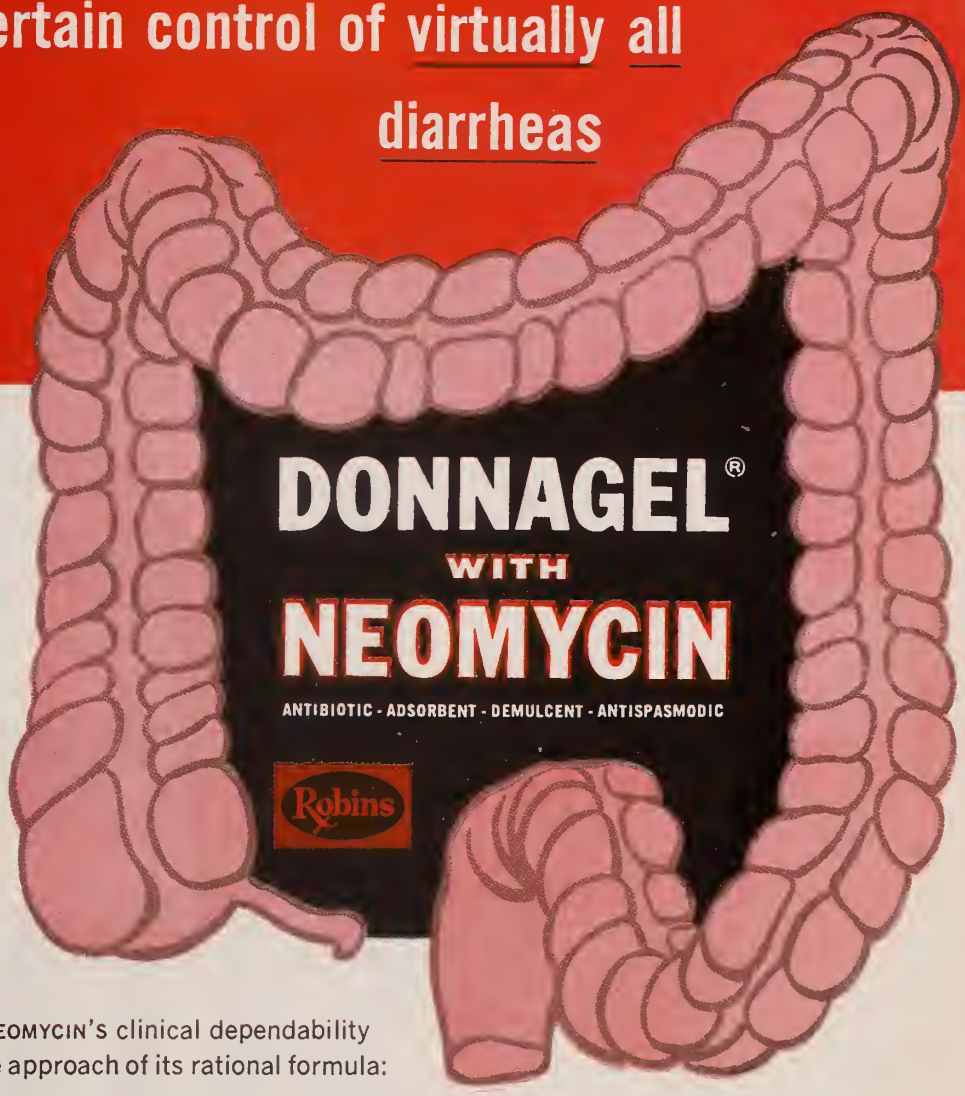
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The Journal of The Florida Medical Association
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Volume XLIV | Jacksonville, Florida, August, 1957 | No. 2

The Evaluation of Procedures Used in The Diagnosis of Hemorrhagic Diseases

L. W. Diggs, M.D.
MEMPHIS, TENN.

It is discouraging for the average physician who desires information about developments in in the field of blood coagulation to be confronted with so much that is unfamiliar and so much that he cannot understand. So many new terms, new diseases and new tests have been introduced that the current medical literature regarding blood coagulation appears to be written in a foreign language. As additional factors are discovered, new theories of blood coagulation are spun and complicated "snakes-by-the-tail" diagrams are presented. Orientation is needed in order to evaluate the relative importance of procedures used in the diagnosis and management of hemorrhagic diseases.

Research in blood coagulation and related problems may be compared with the investigations of the corona of the sun when the sun is in total eclipse. The study of the gases and flames which extend as tenuous and fleeting streaks into the outer darkness gives us essential information about the chemistry of the sun and about the solar mechanisms which cannot be obtained in any other way. On the other hand, the major light and energy of the sun do not come from the relatively thin and luminous envelope that surrounds the sun, but from the central mass. In a like manner, we are dependent for advance of knowledge concerning the factors involved in blood coagulation on investigations of a highly technical nature at the nebulous peripheral zone which separates the known and the unknown. The procedures which are of greatest value in everyday practice are the time-honored history, physical examination, screening laboratory tests and the more simple tests.

Professor of Medicine, University of Tennessee College of Medicine, and Director, Department of Medical Laboratories, University of Tennessee—City of Memphis Hospitals, Memphis, Tenn.

Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 6, 1957.

It is the purpose of this paper to discuss some of the more practical procedures and laboratory tests.

History

The personal and family history is more important than all of the laboratory tests in the diagnosis of diseases characterized by abnormal bleeding. Every individual is daily exposed to tests of trauma. We bump into objects, wear tight clothing, brush our teeth and shave. Cuts, operations, extraction of teeth, menstruation and childbirth reveal the presence of hemorrhagic disease, if it is present. The pattern of many of the hereditary diseases is so characteristic that the diagnosis can be made often from the history alone.

The history should begin at the time of birth and include infancy, preschool, school and adult years as well as recent events. There should be a review of all symptoms with specific questions asked about epistaxis, gingival bleeding, bruises, petechiae, hemoptysis, vomiting of blood, rectal bleeding, hematuria, hemarthrosis and abnormal uterine bleeding. Specific questions should be asked concerning allergy, diet, drugs and exposure to chemicals and poisons. Information about the degree and manner of bleeding and response to various forms of therapy are essential.

Physical Examination

The physical examination gives many leads concerning the diagnosis of hemorrhagic disease. Enlarged lymph nodes and splenomegaly suggest leukemia and other primary diseases of the hematopoietic system. Jaundice, hepatomegaly and spider nevi suggest liver disease. Eyeground changes may suggest bacterial endocarditis or miliary tuberculosis, which may be characterized by hemorrhage as a presenting sign. Puffiness of the eyes, pallor and hypertension suggest ne-

phritis, which is a common cause of hemorrhagic phenomena. A lump in the breast, a pigmented mole or a prostatic mass may be indicative of a tumor, which in its metastasis may be the explanation for thrombocytopenic purpura or fibrinogenopenia.

The distribution of the hemorrhagic lesions is often of diagnostic value. In the majority of patients with purpura of the vascular type the pigmented lesions involve the lower legs and are maximal over the extensor surfaces and pressure points. In purpura of the Henoch-Schönlein type, the lesions are more likely to be over the face, elbows, buttocks and shins, with relatively few lesions on the flexor surfaces and trunk. Senile purpura is characterized by superficial hemorrhages over the backs of the hands and pretibial areas. The petechiae of fat embolism are more numerous over the lateral thorax and shoulder areas. Patients with hemophilia and related diseases have ecchymoses limited to the sites of most recent trauma. In this disease the muscles and joints are often involved, causing deformity and disability.

The type of hemorrhagic lesion is also of aid in diagnosis. In thrombocytopenic purpura there are small hemorrhages without peripheral edema or erythema. In allergic purpuras there is likely to be a zone of erythema and edema around the central hemorrhage. A hemorrhagic lesion with a pale center suggests embolic disease. An area of hemorrhagic necrosis which does not bleed or a skin discoloration of the stocking and glove type suggests occlusive vascular disease. A red spot which partially blanches on pressure is characteristic of telangiectasia. Pigmented and hemorrhagic lesions which itch and have linear scratch marks are indicative of an allergic state.

Black-and-blue areas of the arms and legs of women who bruise easily, in the absence of other signs of abnormal bleeding, are indicative of hereditary purpura simplex. The condition is called by some "the Devil's Nips" because the wife has to have someone to blame when the husband demands to know how she was pinched in such unusual places.

Children with hemophilia and related diseases have elastic tissues which hold the blood from ruptured superficial vessels in tight compartments, giving localized tumor-like lesions. In adults with hemophilia the blood extravasates widely and may involve a large area and deeper structures.

Petechiae limited to the face, neck, shoulders and arms suggest increased capillary fragility caused by breath holding or severe coughing. Annular bands of purpura or purpuric lesions limited to distal areas may be explained on the basis of foundation garments, arm bands or garters. Peculiar hemorrhagic lesions limited to the anterior surfaces of the arms and legs suggest self-induced lesions (purpura factitia) and should lead to close inspection for tooth or fingernail marks or evidences of skin puncture.

Laboratory Tests

The blood smear is the most important of the laboratory tests, for it may reveal the presence of leukemia, aplastic anemia or thrombocytopenia. Enumeration of platelets in 100 oil immersion fields at the thin end of an ordinary blood smear, stained with Wright's stain, is considered to be the most reliable of the platelet counting methods in the hands of the average technologist. No platelet counting methods are accurate. The smear method has an error of more than 100 per cent when the platelet count is normal or increased, but becomes more accurate and reproducible as the thrombocyte count decreases. The normal count is 300 or more per 100 oil immersion fields. A count below 100 per 100 oil immersion fields is significantly low. In thrombocytopenic states there are often less than 50 and sometimes there is less than 1 per 100 fields.

The bleeding time by the Ivy method is informative as a screening test for hemorrhagic disease. In this procedure venous stasis is produced by a blood pressure cuff above the elbow inflated to 40 mm. Hg. The skin of the forearm is punctured to a depth of 4 mm. with a "Hemolet" lancet or equivalent. It is preferable to make two puncture wounds instead of one, for there is considerable variation in the blood flow from different wounds. The drops of blood are collected on filter paper at 30 second intervals until the flow ceases. The technologist should save the filter paper on which the drops of blood are absorbed so that the physician can evaluate the adequacy of the test. The normal bleeding time by the Ivy method is two to six minutes. A bleeding time of six to 10 minutes is equivocal. A bleeding time longer than 10 minutes is significant. Continuance of the test beyond 15 minutes is not recommended.

Routine preoperative tests in order to predict the tendency to bleed at the time of surgery

are not necessary, provided the physician obtains a history, examines the patient, and orders the usual hematocrit determination, white blood cell count, smear examination and urinalysis. Tests for hemorrhagic tendency on all surgical patients are not required by standardizing agencies. A surgeon would not be considered as negligent if he did not perform tests for hemorrhagic disease on all of his patients. Many surgeons, however, prefer to perform preoperative tests routinely. In this case, the tests of choice would be the thrombocyte count by the smear method and the bleeding time by the Ivy method. The bleeding time from a puncture wound of the finger tip is not reliable and should not be accepted as a standard procedure.

The coagulation time by any method is of limited value in the detection of bleeding tendency, for the test may reveal no abnormality in mild hemophilia and other related diseases. The coagulation time of capillary blood by the capillary tube or other micro methods is worthless. If the history or physical examination or screening laboratory procedures furnish evidence of hemorrhagic disease or of conditions commonly associated with hemorrhagic tendency, a battery of preoperative tests should be performed which include the bleeding time, tourniquet test, test tube coagulation time, observation of the clot, and serum and plasma prothrombin activity.

The coagulation test recommended is the four tube method, using venous blood. Care should be taken to withdraw the blood and to place it in the tubes so that frothing or foaming of the blood does not occur. If there is difficulty in venipuncture, the test is unreliable, for admixture of blood with tissue thromboplastin will shorten the clotting time and will mask a deficiency of plasma components. The clotting time of normal blood by the multiple tube method is 15 to 25 minutes. A coagulation time greater than 30 minutes is significant. Many efforts have been made to increase the sensitivity of the coagulation time by dilution, the use of plastic tubes and the coating of tubes with various nonwettable substances, but the clotting times obtained with these methods have been erratic and unpredictable and have not proved to be of clinical significances.

After the clotting time has been performed, the clots should be saved for observation of degree of clot retraction, the volume of red cells which escape from the clot and the character of the clot. In order to measure the volume of expressed serum, it is recommended that 3 to 5 ml. of blood be placed in a graduated, conical test tube. A wooden applicator is inserted and the blood allowed to clot. After four hours at room temperature, the tube is tilted and the clot, attached to the applicator stick, gently removed. The amount of serum expressed from the clot is measured and reported in terms of per cent of original volume. A normal clot on retraction will squeeze out 40 per cent or more of original volume as serum. A defective clot, on the contrary, will not retract as well and will therefore yield less than 40 per cent of serum.

In order to measure the amount of serum remaining on the clot, the volume of the clot is determined. By subtracting the hematocrit value from the volume of the clot the extracorpuscular clot volume is obtained. The normal clot will be relatively dry and will contain 0 to 20 per cent of serum. Values above 20 per cent are indicative of a defective clot.

In obstetric or surgical emergencies in which there is suspicion of fibrinogenopenia and/or fibrinolysis, the observation of the clot character at intervals during the treatment procedure will give valuable information about the condition of the patient and the need for fibrinogen therapy (table 1).

Table 1. — Fibrinogen Deficiency (Defibrination and Fibrinolysis)

Clinical Signs
- Excessive bleeding from uterus or surgical wound
- Bleeding through packs
- Spontaneous bleeding from mucous membranes
- Bleeding from needle puncture wounds
- Ecchymoses of skin

Laboratory Signs
- Prolonged coagulation time
- Escape of red cells from clot
- Small clot
- Lysis of clot

An absence of a clot means complete afibrinogenemia or fibrinolysis (fig. 1). A small clot from which a large volume of red cells has escaped is indicative of fibrinogenopenia, whereas a relatively large clot from which few red cells have escaped is indicative of normal fibrinogen.

The tourniquet test is one of the most sensitive and least informative of the standard so-called "hemorrhagic tests," for a few patients with no demonstrable hemorrhagic disease may have petechiae under conditions of venous stasis and hypoxia. A positive tourniquet test (capillary fragility test) in the absence of a history of bleed-

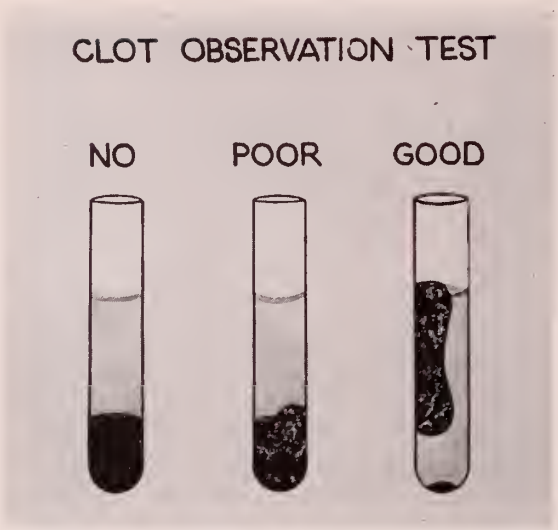


Fig. 1.—The character of the clot and the amount of red cells that escape from the clot are of value in detecting a defect in fibrinogen and in evaluating the response to therapy.

ing and physical signs of abnormality is not a contraindication to surgery. On the other hand, the tourniquet test may be the only sign of abnormality as revealed by the special laboratory tests. In the presence of a history of abnormal bleeding or spontaneous bleeding, the tourniquet test is to be given consideration.

The plasma prothrombin activity test by the one stage method of Quick should be included as a part of the hemorrhagic study on patients with symptoms and signs of bleeding, for this test is of great value in separating the diseases in which there is defective thromboplastin formation (first stage of coagulation) from the second stage of prothrombin conversion (table 2).

Table 2. — One Stage Prothrombin Time (Thromboplastin + Ca + Plasma)

Normal	*Prolonged*
Hemophilia	Prothrombin Deficiency
P.T.C. Deficiency	Labile Factor Deficiency
P.T.A. Deficiency	Stable Factor Deficiency
Thrombasthenia	Fibrinogen Deficiency
	Increased Anticoagulants

The serum prothrombin activity test has now been used for a sufficiently long time to prove its value in the detection of hemorrhagic diseases which may not be revealed by the platelet count, bleeding time, coagulation time and observation of the clot. The serum prothrombin activity test should be available and employed in selected cases in every general hospital laboratory and diagnostic center.

The thromboplastin generation test and tests for accelerator factors and anticoagulants are not practical in the average hospital and should not be attempted unless special facilities are available. These tests require the services of one or more skilled technologists in the preparation of reagents and in the performance of control tests. They also require interpretation by a clinical pathologist with special training in blood coagulation problems. If the physician has a patient with an hereditary hemorrhagic anomaly or a bleeding tendency which cannot be diagnosed by the more simple tests, he should refer this patient to a research or medical center for the performance of the more complicated tests. A patient with hereditary disease has the condition for a lifetime. It would be more economical to have a thorough examination on one occasion by an expert coagulationist than to have incomplete tests performed by untrained technicians on multiple occasions.

Summary

The most important diagnostic procedures are:

A. History
B. Physical examination
C. Screening laboratory procedures
 1. Blood smear examination, including thrombocyte count
 2. Hematocrit reading
 3. Leukocyte count
 4. Urinalysis

The standard hemorrhagic tests recommended are:

A. Thrombocyte count
B. Bleeding time (Ivy method)
C. Tourniquet test
D. Coagulation time (4 tube method)
E. Observation of the clot
F. Plasma prothrombin activity test (one stage method, Quick)
G. Serum prothrombin activity test

The thromboplastin generation and other special tests are necessary in selected patients, but these tests are too complicated to be performed in the average hospital.

Anileridine as an Anesthetic Agent

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Anileridine* (ethyl 1-(4-aminophenethyl)-4-phenylisonipecotate dihydrochloride; anileridine)[1] is a new narcotic agent with an analgesic potency approaching that of morphine and several times greater than than of meperidine. The analgesic effect begins within 15 to 30 minutes after administration and lasts from five to six hours. In dogs, subcutaneous administration of 8 mg. of anileridine per kilogram of body weight produces strong analgesia lasting for over six hours. Unlike morphine, anileridine has shown no emetic action in dogs. The compound is also effective orally. Nalorphine† reverses the action of anileridine, antagonizing both the analgesic effect and the mild respiratory depression produced by the drug.

Because of these properties, anileridine appeared suitable for trial as a primary anesthetic agent.

Narcotics are not newcomers to the field of anesthesiology. In former years, when nitrous oxide held sway as a primary anesthetic agent, the use of heavy premedication was common, since it had been discovered that a satisfactory course under this gas could be more easily obtained if large doses of premedicating agents were given.

The intravenous administration of meperidine and scopolamine in combination has become a well established form of premedication for laryngoscopic, bronchoscopic, esophagoscopic, gastroscopic and cystoscopic procedures, providing greater relaxation and freedom from pain than oral or subcutaneous premedication.

Anesthesiologists who had occasionally used the intravenous route for preoperative medication realized some years ago that narcotics were potential anesthetic agents. In the past few years, various combinations employing a narcotic as the primary analgesic agent have been suggested in the literature, the additional agents generally consisting of nitrous oxide, thiopental sodium and curare. The narcotic was either injected in single intermittent doses or administered as an intravenous drip. Introduction of the narcotic was obviously an attempt to substitute an analgesic agent for an ultra-short-acting barbiturate, the latter having proved unsatisfactory not only because of its lack of analgesic effect but also because of the confusion and prolonged sleep following its use.

Method of Study

To familiarize myself with the method, I chose to combine meperidine hydrochloride with nitrous oxide, thiopental sodium and d-tubocurarine, proposing to use this combination on all patients unless some contraindication existed. Any patient with an easily obtainable intravenous route and a free airway was a suitable candidate. The series consisted of 300 patients, all of whom were scheduled to receive some narcotic in drip form. The method of premedication in established use at Riverside Hospital was retained: a barbiturate at bedtime, a barbiturate one and one-half hours preoperatively, and meperidine hydrochloride and scopolamine one hour preoperatively. The dose of these drugs varied according to the patient's age and weight.

The usual course of anesthesia with thiopental sodium, nitrous oxide and curare proceeds according to the following schedule: Induction begins with the intravenous injection of from 5 to 10 cc. of a 2.5 per cent solution of thiopental sodium. The agent is continued as a dilute intravenous drip (0.2 per cent solution), with the flow adjusted to maintain the anesthetic level. Nitrous oxide and oxygen are given in a 75:25 ratio by the semiclosed method in a total volume ranging between 5 and 7 liters per minute. This excess flow of gas aids in the removal of nitrogen expired by the patient. d-Tubocurarine is added intravenously in intermittent doses, with an initial injection of from 3 to 6 cc., followed by smaller volumes when necessary to ensure relaxation. The patient's respiratory efforts are supplemented by pressure on the breathing bag during inspiration for the entire course of the anesthesia, ensuring adequate oxygenation and rapid loss of carbon dioxide.

From the Department of Anesthesiology, Rivedside Hospital, Jacksonville.

Read before the Florida Society of Anesthesiologists, Jacksonville, Nov. 17, 1956.

Through the courtesy of Dr. S. Clyde Strickland, Merck & Co., Inc., supplied the anileridine for this study.

*Trademark adopted by Merck & Co., Inc., for anileridine is Leritine.

†Trademark of Merck & Co., Inc., for its brand of nalorphine hydrochloride is Nalline.

This method was continued with the addition of meperidine hydrochloride. Intermittent use of the drug was first attempted. Once the anesthetic course had been in progress for five to 10 minutes, the narcotic was administered intravenously. It was soon discovered that doses above 25 mg. produced apnea and hypotension. The depressant effects of thiopental sodium on the respiratory and circulatory centers necessitated smaller doses than would ordinarily be given to a conscious patient. Additional doses of from 6 to 12 mg. of meperidine hydrochloride were injected as required: that is, when increased respiratory rate, quickening pulse, or increasing muscle rigidity led me to believe that further analgesia was necessary.

As experience with this method was acquired, various modifications were tried. First, an attempt was made to reduce the preoperative dose of meperidine. This did not prove wholly successful since reduction of the preoperative dose was apparently reflected by a need for additional drug during surgery. The next step was to discontinue the dilute thiopental sodium solution when the surgical procedure had been in progress for 10 minutes, keeping the vein open with a 5 per cent solution of glucose and water in order to provide a means of giving further injections of meperidine hydrochloride or d-tubocurarine. It must be kept in mind that at this stage one is controlling anesthesia by means of an analgesic agent, a paralyzing agent and a not too potent gas. If the patient is not observed closely, it is possible either to overdose with the narcotic or, conversely, to produce inadequate anesthesia by excessive use of the relaxant drug.

Discontinuance of thiopental sodium early in the surgical course permitted rapid recovery. It was apparent that careful manipulation of the drugs might render the patient capable of moving and opening his eyes before being taken from the operating table. This early recovery promised certain advantages: a rapid return of reflexes would reduce immediate postoperative morbidity and would present fewer problems to personnel in the recovery room.

Next, the method of Ausherman, Nowill and Stephen[2] was instituted. Meperidine hydrochloride was given in a dilute intravenous drip (0.5 mg. per milliliter), either continuously or intermittently as required. As before, thiopental sodium solution was discontinued as soon as adequate anesthesia was established. An average of 75 mg. of meperidine was required, less meperidine being necessary for each succeeding hour of operative time. Far less hypotension and respiratory depression were encountered with this method than with the intermittent single dose method. The gradual decrease in respiratory rate provided a highly sensitive index for decreasing the rate of the injection.

Clinical Trial of Anileridine

Once experience had been gained, anileridine was substituted for meperidine. It was believed that the use of this agent in a dilute drip would be the most satisfactory method. The single small dose method was tried in enough cases to check the potency of the compound, and then the dilute drip method was employed. For this study, anileridine was tried in 100 cases.

Because of the stated potency of anileridine, an initial dose of from 6 to 12 mg. was elected. At no time was 25 mg. exceeded as a single dose. Because of the difference between the hydrogen ion concentration of thiopental sodium and the analgesic, flocculation occurred when these two drugs were mixed, even with the dilute (0.2 per cent) solution of thiopental sodium. Flocculation was severe enough to block the intravenous tubing and needle. Mild respiratory depression occurred even with a dose as small as 12 mg.

Using the concentration of the meperidine drip 0.5 mg. per milliliter) as a basis, a solution of anileridine was prepared in a concentration of 0.3 mg. per milliliter. As with meperidine, the continuous drip method proved more satisfactory than intermittent single dose administration. Thiopental sodium could usually be discontinued as soon as the patient was asleep. The respiratory depression and bouts of mild hypotension occurring with intermittent injections were not as pronounced, despite the rather rapid rate at which the dilute solution was run in during the early period of anesthesia. Study of this series of cases suggests that from 30 to 60 mg. of anileridine is utilized per hour, the amount varying with the type of surgical procedure. The average dose for procedures one and one-half to two hours in length was 35 to 50 mg., as compared with the average dose of 75 mg. of meperidine. The dilute solution can be so titrated that the great majority of patients can be awakened on the table. Discontinuance of the anileridine solution five to 10 minutes prior to the completion of the operation makes it possible to time awakening to coincide with the removal of the mask. It is noteworthy that pain

does not return immediately, postoperative analgesia enduring for as long as two or three hours. Excitement during the awakening appears to be less after anileridine than after thiopental sodium.

Discussion

A sufficient number of endotracheal intubations were performed in completing this series to establish that narcotic agents either in single doses or in continuous drip solution obtund the laryngeal reflexes. Smaller quantities of curare and thiopental sodium were required for smooth unhurried intubation. Less "bucking" occurred following introduction of the endotracheal tube.

The cases in which anileridine was used represented the general run of surgical procedures. Two mitral commissurotomies and one ligation of a patent ductus arteriosus were successfully completed. Two thoracic procedures—a lobectomy and a pneumonectomy—and one craniotomy were among the other operations of particular interest. No difficulty for which this narcotic agent could be held responsible was encountered.

In the more satisfactory cases of the series adequate time was the common denominator. Enough time should be allowed at the beginning of the operation to ensure an adequate level of narcotic in the blood stream and a concomitant flushing-out of nitrogen by the semiclosed method. The required level of narcotic can be attained by a more rapid drip at the beginning of the operation. Liberation of nitrogen requires adequate volume flow of gases per minute and open exhaust valves in the machine.

In conclusion, it may be said that narcotics are now clinically recognized as primary anesthetic agents. Anileridine, a new narcotic, has proved to be adaptable to this particular method. The reason for substituting a narcotic for an ultra-short-acting barbiturate is to provide analgesia rather than sedation; the value of this substitution lies in the possibility for a smoother anesthetic course and a more easily controllable awakening time. This method is not one for the occasional anesthetist. It requires breath-by-breath supervision and should be attempted only by those willing to devote the necessary time.

Summary

In a series of 100 cases in which various surgical procedures were performed, anileridine was administered in place of meperidine as a primary anesthetic agent, in conjunction with nitrous oxide, thiopental sodium and d-tubocurarine. Initial trials with single intermittent doses were later abandoned in favor of the continuous drip method.

The drug appeared to be more potent than meperidine, and with the drip method no significant apnea or hypotension occurred. Patients responded to command before leaving the operating table, and manifested little excitement on awakening. Analgesia appeared to persist up to three hours postoperatively.

The new narcotic appears to be a safe and satisfactory compound for use as a primary anesthetic agent. The combination of anileridine with nitrous oxide, thiopental sodium and d-tubocurarine provides an adequate, controllable, nonexplosive mixture.

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Riverside Hospital.

"Doctors at Work" New Cover Series Begins

On the cover of The Journal this month is the first in a series of pictures showing doctors at work. This series replaces the picture of the Association's headquarters which has been shown on the cover, with one exception, since November 1956.

Believing that an attractive cover encourages reader interest, it is hoped that subscribers to The Journal will find the new cover pictures not only interesting but a source of inspiration.

An attempt will be made to portray as many phases of medical activities as possible, limited by the availability of appropriate photographs.

Progressive Synergistic Bacterial Gangrene of the Skin

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Progressive synergistic bacterial gangrene of the skin is a formidable clinical entity characterized by uncommonly severe pain at the site of a progressive necrosis of the skin. The lesion has a characteristic appearance arising from its three separate and distinct zones (fig. 1). The outer erythematous zone or halo ranges from 0.5 to 4 cm. and fades gradually into the surrounding skin. The middle or necrotic zone is blue-black and elevated sharply 0.5 to 1 cm. above the surrounding halo. The inner or granulating zone consists of necrotic skin, usually gray, resembling suede leather floating unattached on granulations. Cullen[1] is credited with publishing the first case report in 1924. Brewer and Meleney[2] in 1926 established the essential bacteria. Since Cullen's report there have been over 100 reports of typical cases. In 1945 Stewart-Wallace[3] reviewed 37 cases then in the literature. Dodd, Heekes and Geiser[4] added 49 cases up to 1939. Since then many others have contributed to the knowledge of this disease.[5-24] Brewer and Meleney[2] showed the bacteria in the erythematous halo to be predominantly a microaerophilic nonhemolytic streptococcus associated synergistically with hemolytic Staphylococcus aureus in the middle or gangrenous zone. The lesion was reproduced in animals by Meleney[21] only by injection of the two organisms in the identical area of the tissue, thus justifying the name "progressive bacterial synergistic gangrene." He found that if the sites of injection of the organisms were 1 cm. apart, the lesion failed to develop. The streptococcus is believed to invade the tissue (erythematous halo) and prepare it for destruction by the staphylococcus, which produces the middle or gangrenous zone. Tension sutures and drainage tubes have frequently been the site of origin of this lesion, but apparently it may begin in any infected lesion of the skin.

The microscopic pathology is usually described as acute and chronic, nonspecific inflammatory ulcer of the skin. Gangrene of the tissue is superficial, but inflammatory changes usually occur down to or through the muscle fascia. The changes are primarily perivascular infiltration of inflammatory cells. Only one author reported thrombophletitis in the subcutaneous tissue and cited this as the cause of the necrosis of the skin.

The lesion is noncontagious.

The most characteristic symptom is extremely severe pain at the site of a superficial ulcer of the skin having a characteristic appearance. Anorexia, exhaustion and mental depression, as well as hypoproteinemia, anemia, and electrolyte imbalance, appear as the lesion progresses.

Treatment

Many kinds of therapy have been used including quartz light, hypertonic saline, immunized blood transfusion, maggots, roentgen therapy, various antiseptics and vitamins, minerals, salvarsan and vaccine, without satisfactory results. The current therapy of choice consists of immediate bacterial analysis with determination of antibiotic sensitivity followed by intensive treatment with drug or drugs of choice.

If a reasonable period of treatment fails to halt the progress of the lesion, excision of the ulcer en bloc with application of zinc peroxide dressings should proceed without further delay. The excision should include 3 cm. of skin beyond the erythematous halo and all of the subcutaneous tissue to the deep fascia. Immediate grafting would appear to be in order; however, there is some danger of spreading the lesion to the graft site. It may be preferable to maintain dressings saturated with zinc peroxide solution on the denuded area for seven to 10 days until a recurrence seems unlikely before attempting grafting. The conscientious application of zinc peroxide paste dressings frequently enough to keep the dressings constantly moist is essential to the destruction of

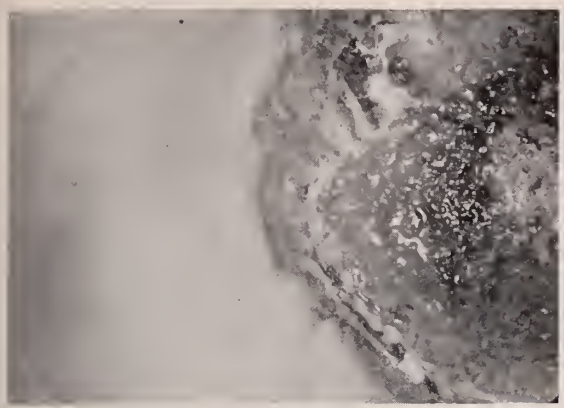


Fig. 1. — Photograph of edge of ulcer demonstrating the three zones.



Fig. 2.—Twenty-nine days after injection the ulcer was large and was excised the next day.

the microaerophilic streptococcus that contaminates the surface of the area after excision. Penicillin[24] and bacitracin[25] have been curative, obviating surgery in some cases. Side contaminants such as Escherichia coli and Pseudomonas pyocyanea may produce penicillinase and thus make it ineffective.[25]

Many fatalities have occurred as the result of this entity, but with the use of the plan of treatment described deaths should be rare.

Report of Case

On April 1, 1955, the patient was first seen with cellulitis and lymphadenitis of considerable degree on the left side of the neck following extraction of a tooth. She elected, for financial reasons, not to be hospitalized and was given 300,000 units of Wycillin intramuscularly and advised to use local heat at home. On the next day her condition was unchanged, and Terramycin, 250 mg. four times a day orally, was prescribed. A sample ampoule of Tetracyn was given intramuscularly in the upper outer quadrant of the left gluteal area.

By April 7 the inflammatory process had completely subsided except for residual palpable nodes in the anterior cervical triangle, but there was an area of cellulitis 5 cm. in diameter at the site of the Tetracyn injection in the left gluteal area. Heat to this area was advised, and on April 9 several small blisters with serous content were noted in the center of the erythematous gluteal area. This area was uncommonly painful, causing loss of sleep and much difficulty in walking, but there was still no fluctuation. Heat was continued at home, and two days later the patient reported that a small amount of drainage had escaped. On April 15 it was noted that there was no deep draining sinus, rather a superficial ulceration of the skin 3 cm. in diameter with a bluish black, 2 mm. margin of skin surrounded by an erythematous halo measuring 2 cm. On April 18 the ulceration measured 4.5 cm.; the black margin of skin was slightly elevated and 0.5 cm. wide with the red halo of erythema unchanged. It then was recognized that this was probably progressive synergistic bacterial gangrene of the skin, and the patient was admitted to St. Francis Hospital in Miami Beach.

On admission, laboratory work was as follows: Urinalysis revealed a faint trace of albumen, 2 plus acetone and 4 to 6 white blood cells. Blood analysis showed 4,340,000 red blood cells with a hemoglobin estimation of 12.3 Gm. and 15,500 white blood cells with 94 per cent polymorphonuclear cells and 6 per cent lymphocytes. The VDRL reaction was negative.

Panmycin, 500 mg. every six hours, was given intramuscularly with hot packs locally to the lesion until April 21 when culture revealed Staph. aureus sensitive to Furadantin, Chloromycetin and bacitracin. Chloromycetin, 100 mg. every four hours, with local hot packs was given until April 26 with no effect on progress of the lesion. At this point 20,000 units of bacitracin intramuscularly every eight hours and 2,000,000 units of intravenous crystalline penicillin every 24 hours with local application of bacitracin to the ulcer were started. The temperature to April 21 had not exceeded 99 F. On April 30 bacitracin was increased to 25,000 units every six hours.

It was obvious on May 1 that the ulcer was progressing steadily (fig. 2), and on the next day excision of the ulcer was carried out. A 2 cm. margin of normal skin beyond the border of the erythema was included along with all subcutaneous tissue down to the fascia. The pathologic report was an acute and chronic inflammation of the skin, nonspecific, the specimen measuring 21 by 20 by 3.5 cm. Grafting of the defect was not attempted at this time, and a dressing saturated with 40 per cent aqueous solution of medicinal zinc peroxide was applied. From April 22 to April 25 the temperature spiked progressively daily until on May 3, the day following excision, it reached 104 F. Thereafter it fluctuated between 99 and 100 F. until June 9 when it dropped to normal for the remainder of the hospital stay. The high temperature on May 3 was believed to be the result of a pelvic cellulitis accompanying a spontaneous abortion.

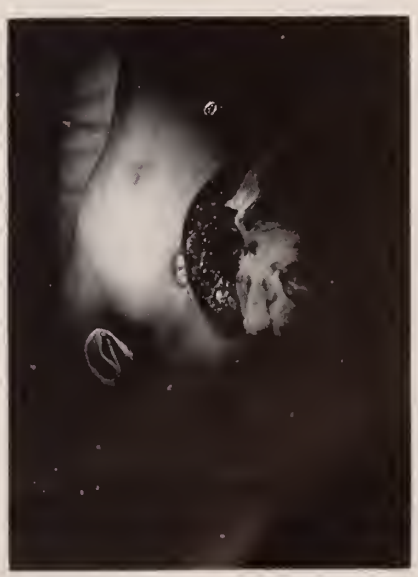


Fig. 3. — Recurrence is seen on left margin of area excised nine days preceding this picture.



Fig. 4. — Dorsal view of defect after grafting. Epithelialization is complete. On May 1, 1956 no scar contractures had developed.

After excision the bacitracin and penicillin were discontinued, and Panmycin, 250 mg. every six hours, with continuous local wet dressings of a solution of 300,000 units of penicillin per liter were used. Daily urinalysis during this period revealed only faint traces of albumin with occasional cells.

On May 11 three marginal recurrences were observed (fig. 3). Split thickness grafts were taken from the right thigh, and after this area was dressed to prevent contamination, the recurring lesions were excised with a margin of 2 cm. of normal skin. Grafts were placed and Aureomycin-impregnated gauze with zinc peroxide solution about the periphery of the excision was placed in a pressure dressing. The pathologic report was acute and chronic inflammation of the skin with ulceration, the three specimens of skin and subcutaneous tissue measuring 15 by 15 by 2 cm., 5 by 3 by 2 cm., and 3.5 by 1.8 by 1.5 cm. Thereafter, the Aureomycin gauze was used to dress graft, and zinc peroxide solution was used on the skin margins daily.

By May 19 two recurrences were noted on the margins of the lesion and these areas were excised with the taking of 3 cm. of normal skin beyond the edge of the erythematous halo. At this time the graft site was dressed for the first time, and three typical ulcers were noted on the donor area. These were excised, with the taking of as wide an area of normal skin as described previously. The pathologic report was acute and chronic inflammation of the skin and multiple skin ulcers, the six specimens measuring 2.3 by 2 by 2.1 cm., 7.5 by 4.2 by 1.2 cm., 5 by 5.5 by 3 cm., 6 by 3.2 by 3 cm., 3.1 by 2.8 by 1 cm. and 3 by 3.3 by 2 cm. The excised areas of the thigh and of the parent lesion were flooded with zinc peroxide solution and after 24 hours these areas were flooded with this excellent medication every 24 hours. On May 21 the total protein was 5.7 Gm. with 3.3 Gm. of albumin and 2.4 Gm. of globulin. The gamma globulin fraction was .85 Gm. per hundred cubic centimeters. The granulating areas (only 70 per cent of the graft "took") remained clean, and by June 14 only small areas remained unepithelialized. The application of zinc peroxide was continued up to June 10.

Blood and electrolyte solutions were given as necessary throughout the period of hospitalization. Altogether four cultures were made with the use of anaerobic technic each time, but the streptococcus was never isolated.

It was almost impossible to persuade the patient to eat. Her caloric intake was much below minimum requirement, and she lost 22 pounds while hospitalized. Forced feeding through an indwelling tube was not tolerated by the patient. Vitamin C, 1,000 mg. along with multivitamins, was given daily, orally after the first excision. Liberal doses of narcotics were necessary to control the pain of the lesion, particularly from April 18 to the time of the first excision on May 2. After the last excision the narcotic consumption precipitously declined, and the anorexia and malaise improved remarkably. On August 30 the photograph shown in figure 4 was taken in the office, revealing great loss of tissue, but showing the lesion completely epithelialized and asymptomatic. She has gained 18 pounds in two months and feels she has completely recovered.

Discussion

Although great pains were taken to culture the organisms (including cultures from the cut surfaces of tissue in the halo zone), the nonhemolytic streptococcus was never cultured. Perhaps the antibiotics used prior to culture interfered. Careful anaerobic methods are necessary to grow the streptococcus.[26]

The literature leads one to the conclusion that any infected wound may become the site of this lesion. The pH of Tetracyn is 3.5, and we observed for one month another case of fat necrosis resulting from intramuscular injection of this drug that was suspected of being a "Meleney's ulcer." There is no intention to incriminate Tetracyn as the cause of this lesion. It seems likely, however, that an area of fat necrosis produced by the injection of Tetracyn was the lesion that became infected to produce the progressive synergistic bacterial gangrene of the skin.

The ability of this ulcer to spread to other areas of the body — in this case the donor site — is emphasized by this case. Fortunately wide excision and intensive zinc peroxide therapy cured these lesions promptly.

It is difficult to overemphasize the extreme pain associated with the lesion. Even while the lesion was small (5 cm. in diameter), the patient found it difficult to walk and almost impossible to sleep. Her absolute refusal to recline on other areas than the opposite hip demanded a maximum effort by the nursing staff to prevent a decubitous ulcer of this area. Needless to say, the constant and efficient nursing care from this standpoint and that of nutrition was largely responsible for her recovery.

Since no recurrence followed the most zealous postexcision application of zinc peroxide paste, it seems reasonable to conclude that it was essential to the successful outcome of this case, which failed to respond to the antibiotics. Meleney[27] has urged its use in such cases. Medicinal zinc peroxide should be sterilized in an oven for four hours at 140° centigrade. Water suspension is best, but it may be used in Carbowax (polyethylene glycol), a water-soluble base in areas difficult to keep moist. Its end products are zinc oxide and zinc hydroxide and these are harmless chemicals to the tissue. It is obviously important that the zinc peroxide be activated, and there is a simple test to determine its activation.[27]

Conclusion

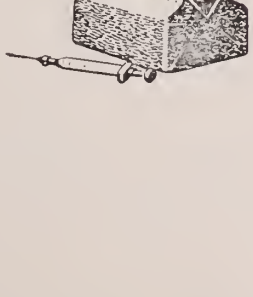
A case of progressive synergistic bacterial gangrene of the skin resistant to antibiotic therapy is presented. It required three separate surgical attacks on recurrences and spread to other areas of the body (donor site) before it finally was controlled.

The appearance of a black middle zone in any spreading ulcer of the skin demands consideration of progressive synergistic bacterial gangrene of the skin in the differential diagnosis. Expeditous culture and antibiotic sensitivity studies followed by intensive antibiotic therapy are imperative. If the lesion continues to progress after reasonable trial on the proper antibiotics, wide excision is mandatory in order to prevent considerable deformity resulting from tissue loss and/or death. Zinc peroxide is essential in the treatment of those lesions requiring excision.

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Cost of Administration Of Salk Vaccine Program

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The Federal Polio Act of 1955 allotted $780,000 to Florida for a program of vaccination against poliomyelitis. According to the plan, Florida was allowed to use $564,000 of this amount for the purchase of vaccine and $216,000 for its administration. It was necessary, however, that all money used for purposes other than for the purchase of vaccine be validated in some manner consistent with the accounting principle of the U. S. Public Health Service.

In some states, in order to validate these funds, every employee, both state and local, devoting any time to the program, was being required to keep a strict time record of all appropriate activities. The Florida State Board of Health and its Poliomyelitis Advisory Committee, however, realized that such a procedure would burden an unnecessarily large number of people and might, in some of the more understaffed counties, result in decreased efficiency in carrying out the immunization.

It was, therefore, decided that in this state, three jurisdictions, as nearly as possible representative of the state as a whole, would be selected to make the validation time and cost studies. For this purpose were chosen Orange County, Leon County, and the tricounty unit encompassing Franklin, Gulf, and Wakulla counties. Orange County was considered to be representative of a large county, an urban area, and a locality in which most of the immunizations would be given by private physicians. Leon County, on the other hand, was believed to be a rather typical county of average size with mostly urban population where the immunization program would be carried out almost entirely by the Health Department. The tricounty jurisdiction was chosen to represent small rural counties in which most of the immunizations, by necessity, are given by the Health Department.

The School of Public Administration of Florida State University** was most helpful by assisting in the planning of the time and cost study itself, and the necessary forms were prepared by that school. The basic form was an "Individual Daily Time and Travel Sheet," which was completed daily by every person taking part in the polio vaccination program. On this sheet, the time consumed in each of 11 categories was noted. These activities were: planning of the program; administration of program—records, reports, consent slips; distribution of vaccine; advance preparation of vaccine, syringes, and other supplies; administering injections; educational activity—lectures, publicity, evaluation of the program; investigation of reactions, cases and suspected cases; collection of laboratory specimens; giving of information on the telephone or in person, and miscellaneous activities not covered in any of the other 10 categories. The number of miles traveled in the performance of these various activities was also recorded.

Each county, on a monthly basis, compiled the total time and miles devoted to the vaccination program by worker and by type of activity. These figures with the hourly wage of each worker make possible a determination of the total cost of the program, the cost of each worker's contribution, and the cost by activity. It was thought that the counties selected for the study were sufficiently representative of the state as a whole to warrant using the average cost in these counties to estimate the cost of the statewide program. Thus, the total cost to the state could be obtained by multiplying the average cost per injection by the total number of injections given in the state and adding the costs of the State Board of Health's part in the over-all program.

Of the $216,000 designated for administration of the program, $171,000 was assigned to county

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Read before the Florida Health Officers Society, Eleventh Annual Meeting, Miami Beach, May 13, 1956.

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health departments, and $45,000 was reserved to defray the costs of the program to the State Board of Health. Through March 31, 1956, $16,910.51 of this amount had been expended for such items as: travel and expenses of the State Advisory Committee, the purchase of health education materials, publicity, personnel and equipment to carry out statistical procedures, salaries of a program director and his stenographer, and the cost of personnel and equipment to carry out a virological diagnostic service.

Table 1. — Cost of a Program for Administering Poliomyelitis Vaccine in Selected Florida Counties, August 12, 1955 through March 31, 1956

County	Population	Total Local Cost	Number of Injections	Cost per Injection
Orange	176,402	$5,065.08	18,819	$0.269
Leon	59,995	3,012.97	11,025	0.273
Franklin Gulf Wakulla	19,818	2,876.20	2,925	0.983
Totals	256,215	$10,954.25	32,769	$0.334

From table 1, one learns that Orange County gave 18,819 injections of poliomyelitis vaccine at a total cost of $5,065.08 or $0.269 per injection. In Leon County, 11,025 injections were given at a total cost of $3,012.97 or $0.273 per injection. The tricounty area, including Franklin, Gulf, and Wakulla counties, gave 2,925 injections for $2,876.20, which makes the cost per injection $0.983. In the study area as a whole, the total cost for giving 32,769 injections was $10,954.25, or $0.334 per injection.

In the three areas studied, only the rural area had costs out of line with the average of the three jurisdictions. It was thought, therefore, that unless the proportion of rural to urban in the study area approached that proportion for the state as a whole, the bias would be too great to permit using the simple arithmetic average cost per injection in the study and to determine the statewide cost. It was determined that in the state as a whole, 9.2 per cent of the population lives in counties having a population of less than 20,000. In the study area, this proportion was found to be 7.8 per cent.

If the average cost per injection ($0.334) in the study area is multiplied by the total number of injections (404,470) given throughout the state, it is found that the total cost of the vaccination program to the counties was $135,092.98.

Average Local Cost per Injection	Total Injections in State	Total Local Cost in State
$0.334	404,470	$135,092.98

If the expenditures of the State Board of Health ($16,910.51) are added to the local cost, the total cost of the program is found to be $152,003.49. This figure does not take into consideration a large number of minor and incidental expenses such as the proportionate share of the costs of utilities, telephone, rent, stationary and other office and clinic supplies. An estimate of 5 per cent of the total cost of the program is thought to be a reasonable allowance for these expenses. Thus the total cost of the program to the taxpayers from August 12, 1955 through March 31, 1956 was $159,603.66, or $0.395 per injection.

Total Local Cost	State Expenditures	Total Cost of Program
$135,092.98	$16.910.51	$152,003.49

Total Cost of Program	Estimated 5 Per Cent for Miscellaneous Expenses	Total Adjusted Cost to Taxpayer for 404,470 Injections
$152.003.49	$7,600.17	$159,603.66 ($0.395 per injection)

Explanations

While statistics are available which would enable one to determine the cost of the various phases of the immunization program, it was the purpose of this report to give only the over-all costs. A more complete report will be made when the study is completed.

Because of the time lag in obtaining from private physicians reports on immunizations completed, the use of reported immunizations in computing the cost of the program would be misleading in that Orange County, in which most of the immunizations are given by private physicians, would have an unusually high cost. The amount of vaccine distributed was therefore used rather than the number of injections reported. This is justifiable since the expenses under consideration are ended when the vaccine has been distributed to the private physician.

Conclusions

Several tentative conclusions or observations can be made from this incomplete Time-Cost Study. Chief among them are:

1. That the probable cost to administer 404,470 doses of poliomyelitis vaccine to Florida's children was $159,600 or $0.395 per dose. This figure does not include the cost of the vaccine or fees paid to private physicians by individuals.

2. That the cost of a county program of distribution of vaccine to private physicians with the

necessary collection of reports and other supportive activities was essentially the same as for a county program in which practically all immunizations were given by the health department.

3. That the cost of the immunization program in the rural counties was more than twice the cost found for either urban county. This is additional proof that the cost of rural public health is high.

It is realized that a study of this sort is subject to a great many sources of error. The counties selected as the sample may not be typical or representative of the state as a whole. There could also be great variability in the daily accounting of time by the individual workers. It is believed, however, that the study was sufficiently well controlled to determine roughly the cost of administering the vaccine. It should also be emphasized that this is an interim report and that the costs found at this time may not be the same as those computed when the study is completed.

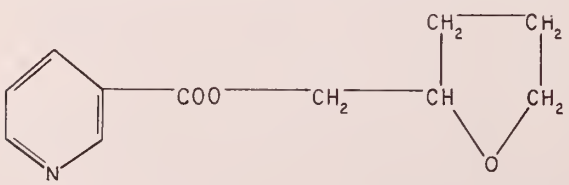
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Skin Reactions to a Nicotinic Acid Ester In Tuberculosis

Studies with Tetrahydrofurfuryl Ester of Nicotinic Acid

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The use of nicotinic acid derivatives in the treatment of tuberculosis led us to study the possible effects of such therapy on a skin test developed as a diagnostic aid in active rheumatic fever.[7,10] We described an atypical response to the topical application of an ointment containing the tetrahydrofurfuryl ester of nicotinic acid* in patients with active rheumatic fever. This reaction differed from the erythematous and/or edematous response observed in normal persons and patients with inactive rheumatic disease. It was characterized by failure of the skin to redden or by actual blanching at the site of application of the ointment. The mechanism of this reaction in rheumatic fever may be related to altered metabolism of nicotinic acid or its precursors. Disturbances in metabolism of the precursors of nicotinic acid have also been reported in tuberculosis.[1] This and certain other similarities between the two diseases appeared to warrant the investigation of the skin responses to tetrahydrofurfuryl ester of nicotinic acid of patients with tuberculosis. Both tuberculosis and rheumatic fever are characterized by chronic activity and debilitating effects. Bacterial hypersensitivity may be implicated in the pathogenesis of each disease (to Mycobacterium tuberculosis in tuberculosis, and to Streptococcus pyogenes in rheumatic fever).



In view of these similarities, a study of the influence of tuberculosis and of isonicotinic acid hydrazide therapy on the cutaneous response to the tetrahydrofurfuryl ester of nicotinic acid provided a logical approach to obtain further information on the mechanism and specificity of the skin test. This is a report and discussion of our findings in a series of 166 patients suffering from tuberculosis.

Material and Method

The skin response to topical application of a Vaseline-lanolin ointment containing 5 per cent tetrahydrofurfuryl ester of nicotinic acid was determined in 166 patients with pulmonary tuberculosis at the Southeast Florida Tuberculosis Hospital at Lantana. The patients ranged in age from 17 to 81 years; there were 88 males and 78 females; 76 were white, and 90 were Negro. Other diseases complicated the tuberculosis in 44 patients. Mycobacterium tuberculosis was recovered from the sputum of all the patients immediately prior to hospitalization; 91 patients had a positive

Read before the American College of Chest Physicians, Interim Session, Boston, Mass., Nov. 28, 1955.
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Supported in part by a research grant from Ciba Pharmaceutical Products, Inc., Summit, N. J.
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sputum at least once during the six month period prior to skin testing. Symptoms and signs on admission varied from mild to severe. At the time the skin tests were performed, clinical and roentgenologic evaluations by the physicians and consultants in charge revealed that in 146 patients the disease was considered definitely active. In the remaining 20, it was indeterminate or quiescent.

Fifty-three patients were receiving isonicotinic acid hydrazide or other isonicotinic acid derivatives, in varying dosages. Other forms of therapy also were used in these 53 patients, as well as in all of the remaining patients. Such treatment included para-aminosalicylic acid, streptomycin and other antibiotics, multivitamins, and surgery. No tests were performed during the immediate postoperative period. The method of skin testing was the same as previously described.[7,10] An ointment of 5 per cent tetrahydrofurfuryl ester of nicotinic acid in Vaseline-lanolin base was rubbed into the volar aspect of the forearm of each patient. A second ointment, consisting of the same base, but without the nicotinic acid ester, was applied in the same manner to another portion of the forearm. The normal response was a hyperemia and/or edema occurring within 30 minutes. Responses were recorded as typical, borderline typical, borderline nontypical or nontypical, as outlined in table 1.

All skin tests were performed and interpreted "blindly" by us without knowledge of the clinical status of activity of the disease in any patient, nor were the clinicians aware of the test results.

As controls for evaluation of the specificity of the skin test, 74 healthy persons were studied.

Table 1. — Method of Reading Tetrahydrofurfuryl Nicotinic Acid Ester Inunction Test

Type of Reaction		Erythema in		Edema
		Ointment Zone	Spread Zone	
Typical (normal)	1.	+	— to +	— to +
	or 2.	— to +	— to +	+
	or 3.	±	+ > ¼″	—
Borderline typical (normal?)	1.	±	± > ¼″ or + > ⅛″ and < ¼″	—
Borderline nontypical (abnormal?)	1.	> ± fading within 30 min.	—	—
	or 2.	±	+ < ⅛″ or ± > ¼″	—
Nontypical (abnormal)	1.	O or —	O or —	—
	or 2.	± fading within 30 min.	—	—
	or 3.	—	+ < ⅛″ or ± < ¼″	—

KEY:
1. O = Blanching without edema
2. — = No visible erythema, no edema
3. ± = Barely perceptible erythema
4. + = Perceptible erythema and/or edema

NOTE: Edema is never present in a nontypical response.

Results

Skin responses to the tetrahydrofurfuryl ester of nicotinic acid were observed in 166 patients with tuberculosis (table 2). Normal (typical or borderline typical) reactions were noted in 148 patients (90.2 per cent); abnormal (nontypical or borderline nontypical) reactions, in 16 patients (9.8 per cent); and nonreadable reactions, in two patients.

Table 3 indicates that 38 (88.4 per cent) of 43 patients with other conditions complicating the tuberculosis had typical or borderline typical reactions. Five patients (11.6 per cent of the 43) had nontypical or borderline nontypical responses. There was one reaction which could not be read.

Of 91 patients (table 4) with positive sputums some time during the six months immediately prior to the skin testing, 89 per cent responded normally, while 11 per cent responded abnormally.

Among the 53 patients receiving therapy with one of the isonicotinic acid derivatives (table 5),

Table 2. — Skin Responses of 166 Patients with Tuberculosis to Tetrahydrofurfuryl Ester of Nicotinic Acid

Type of Skin Response	Patients	
	Number	Per Cent
Typical	144	
Borderline typical	4	
Total normal	148	90.2
Nontypical	9	
Borderline nontypical	7	
Total abnormal	16	9.8
Total	164	100.0
Nonreadable	2	—

Table 3. — Skin Responses of 44 Patients with Tuberculosis Complicated by Other Diseases to Tetrahydrofurfuryl Ester of Nicotinic Acid

Type of Skin Response and Complication	Patients	
	Number	Per Cent
Typical response		
Treated syphilis	19	
Diabetes	5	
Pregnancy	3	
Hypertensive heart disease	3	
Arteriosclerotic heart disease	3	
Congenital heart disease	2	
Peptic ulcer	1	
Myasthenia gravis	1	
Total typical	37	86.1
Borderline typical response		
Treated syphilis and alcoholic cirrhosis	1	
Total borderline typical	1	2.3
Total Normal	38	88.4
Nontypical response		
Asthma	1	
Diabetes	1	
Renal lithiasis	1	
Total nontypical	3	7.0
Borderline nontypical response		
Peptic ulcer	1	
Epilepsy, alcoholism and latent syphilis	1	
Total borderline nontypical	2	4.6
Total abnormal	5	11.6
Nonreadable (diabetes)	1	—

Table 4. — Skin Responses of 91 Patients with Sputums Positive for Tubercle Bacilli to Tetrahydrofurfuryl Ester of Nicotinic Acid

Type of Skin Response	Patients	
	Number	Per Cent
Typical	79	
Borderline typical	2	
Total normal	81	89.0
Nontypical	3	
Borderline nontypical	7	
Total abnormal	10	11.0
Total	91	100.0

50 (94.4 per cent) reacted normally, while only three (5.6 per cent) gave abnormal responses.

Of the 74 control subjects, only three (4.1 per cent) showed no erythema or edema in response to the skin test.

Table 6 summarizes the responses with reference to all the factors studied. The presence of a complicating disease, or the finding of a positive sputum, increased, though only slightly, the percentage of abnormal skin responses. Isonicotinic acid hydrazide therapy, on the other hand, decreased the percentage of abnormal responses to 5.6 per cent—toward the control figure of 4.1 per cent.

Discussion

Patients with active tuberculosis do not respond to skin testing with the tetrahydrofurfuryl ester of nicotinic acid in the same way as do patients with active rheumatic fever. Despite the similarities of the two diseases as regards tendency to chronic activity, debilitating effects, and implication of a hypersensitivity mechanism in their etiology, of 60 patients (table 7) with active rheumatic fever, 87 per cent gave abnormal responses[11] as against only 9.8 per cent of 164 tuberculous subjects (table 2).

These findings are substantially in accord with those reported by Weiss,[13] who found that 3 per cent of 33 patients with active tuberculosis gave abnormal skin test responses. The higher number of atypical reactions (9.8 per cent) observed by us may be attributable to purely statistical differences, to other factors such as therapeutic agents employed in each individual patient, or to slight differences in criteria for interpreting the skin response. Atypical reactions were observed in only 4.1 per cent of our 74 healthy controls. Because the number of subjects in control, rheumatic and tuberculous groups is small, differences in percentages of abnormal responses cannot be definitely evaluated. It has been reported[4] that in tuberculosis, there is an abnormality in the catabolism of tryptophan to nicotinic acid, as indicated by increased urinary excretion of 3-hydroxyanthranilic acid. Abnormal tryptophan metabolism also has been observed[11] following the administration of isonicotinic acid hydrazide to

Table 5.—Skin Responses of 53 Patients on Isonicotinic Acid Hydrazide Therapy to Tetrahydrofurfuryl Ester of Nicotinic Acid

Type of Skin Response	Patients	
	Number	Per Cent
Typical	48	
Borderline typical	2	
Total normal	50	94.4
Nontypical	1	
Borderline nontypical	2	
Total abnormal	3	5.6
Total	53	100.0

Table 6.—Summary of Skin Responses of 166 Tuberculous Patients to Tetrahydrofurfuryl Ester of Nicotinic Acid

Status of Tuberculosis	Patients	
	Total Number	Per Cent Abnormal Responses
Complicated by other diseases	43	11.6
Uncomplicated	121	9.1
Positive sputum within 6 mos. of test	91	11.0
Negative sputum within 6 mos. of test	73	8.2
On isonicotinic acid hydrazide therapy	53	5.6
Not on isonicotinic acid hydrazide therapy	111	11.7
Controls (no tuberculosis)	74	4.1

tuberculous subjects. We therefore considered the skin test responses to tetrahydrofurfuryl ester of nicotinic acid worthy of analysis from the standpoint of the relationship of the test to the tryptophan–nicotinic acid series, for "considerable evidence has been adduced from work in animals and microorganisms to show that nicotinic acid may be formed from tryptophane (sic)."[2] Figure 1, based on established data,[3] shows reported relationships between various diseases and abnormalities in tryptophan catabolism.

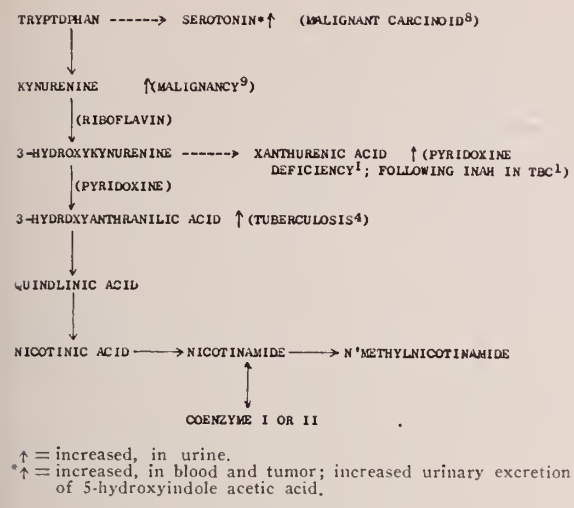
The possibility that isonicotinic acid hydrazide therapy may interfere with normal metabolism of some of the vitamin B complex components (nicotinic acid, pantothenic acid, pyridoxine) in tuberculosis has been postulated.[5, 6] Pegum[6] first described the "burning feet" syndrome resulting from isonicotinic acid hydrazide therapy and suggested that either pantothenic or nicotinic acid deficiency might be responsible. McConnell and Cheetham[5] noted that pellagra developed in a tuberculous patient after isonicotinic acid hydrazide therapy; the pellagra was cured by the administration of vitamin B complex. Biehl and Vilter[1] noted peripheral neuritis in 40 per cent of their patients receiving isonicotinic acid hydrazide therapy, but not in those patients receiving pyridoxine in addition to the hydrazide. These investigators demonstrated increased excretion of xanthurenic acid following the administration of test doses of isonicotinic acid hydrazide to tuberculous patients; the rise in xanthurenic acid excretion was proportional to the dosage of isonicotinic acid hydrazide. The urinary excretion of N'-methylnicotinamide, product of nicotinic acid metabolism, was not affected.

Possible sources of nicotinic acid in these tuberculous patients may be from: (1) diet and vitamin therapy (all of the patients in the present investigation received supplemental vitamin therapy), (2) reserves of coenzymes I and II, (3) other metabolic systems, and (4) increased tryptophan catabolism. We may speculate that most tuberculous patients maintain normal nicotinic acid supplies from one or more of these sources, and that normal skin test responses depend on an adequate skin concentration of the acid itself, some closely related substance, or some compound of which it is a component (such as coenzyme I or II). Only occasionally, in tuberculosis, will the available supply of the requisite skin test factor be diminished sufficiently to re-

Table 7.—Comparison of Abnormal Skin Responses in Tuberculosis, Rheumatic Fever and Health

Disease	Number Tested	Per Cent Abnormal
Active rheumatic fever	60	87.0
Tuberculosis + sputum*	91	11.0
Tuberculosis — sputum*	73	8.2
Healthy controls	74	4.1

*Sputum positive or negative during six months prior to skin testing.



↑ = increased, in urine.
*↑ = increased, in blood and tumor; increased urinary excretion of 5-hydroxyindole acetic acid.

Fig. 1. — Tryptophan Catabolism.

sult in an abnormal skin response.

In our series of tuberculous patients who were on long term isonicotinic acid hydrazide therapy, there was a lower percentage of abnormal skin responses (5.6 per cent) than in those patients who did not get this drug (11.7 per cent). Several hypotheses may be offered to explain this apparent effect of therapy. Patients on isonicotinic acid hydrazide therapy may approach normal health, reflected in normal nicotinic acid metabolism, and therefore display normal skin reactions. Isonicotinic acid hydrazide, in tuberculous patients who show abnormal skin responses, may replace a deficiency in the tissues or capillary walls of the skin of nicotinic acid, of one of its metabolites, or of some compound containing nicotinic acid or its amide. There may be other mechanisms, as yet undescribed, which are responsible for the higher rate of normal skin responses in patients on isonicotinic acid hydrazide treatment. The effect of single doses of isonicotinic acid hydrazide was observed by Weiss,[13] who administered 100 mg. of isoniazid to each of 14 normal subjects, and noted an atypical skin reaction in two instances. On the other hand, when he gave 200 or 300 mg. to 28 additional persons, no abnormal skin response ensued.

We suggested[7] that altered nicotinic acid metabolism might explain the tendency of patients with acute rheumatic fever to respond abnormally to the skin test. Recently, this concept has been investigated further by Weiss.[12] He observed atypical skin responses in patients with acute tonsillitis. Of 14 such patients fed nicotinamide (800 mg. per day), 13 gave a normal skin test by the fifth day, while only six of 14 tonsillitis controls responded with a normal skin reaction in the same period of time. He was unable to demonstrate correlation of blood levels of nicotinic acid with the type of skin reaction observed, although "serial determinations suggested that in patients with acute infections, the blood concentration of nicotinic acid tends to rise within the normal range as the disease subsides."[14]

Further investigation of the tryptophan–nicotinic acid catabolic series and its relationship to the tetrahydrofurfuryl ester of nicotinic acid skin test is in progress in our laboratory.

Summary

Skin responses to inunction with an ointment containing 5 per cent tetrahydrofurfuryl ester of nicotinic acid were observed in 166 patients hospitalized because of active tuberculosis, and were compared with those seen in 60 patients with active rheumatic fever and in 74 healthy control subjects.

In the tuberculous group, 148 patients (90.2 per cent) gave normal responses, while 16 (9.8 per cent) gave abnormal reactions; two patients gave nonreadable reactions. These results were in contrast to those observed in active rheumatic fever, where 87 per cent of the patients gave abnormal responses. Abnormal reactions occurred in 4.1 per cent of the healthy controls.

Isonicotinic acid hydrazide therapy seemed to lower the percentage of abnormal reactions (5.6 per cent) when compared with the percentage (11.7 per cent) in the group of patients not receiving this medication. No definite conclusion, however, can be drawn as to the effect of such therapy because of the small number of patients in each category.

The abnormal cutaneous response observed in patients with active tuberculosis could be linked neither to the chronicity of the disease, nor to activity as indicated by the presence of tubercle bacilli in the sputums at some time during the six months prior to skin testing, nor to the effects of any particular form of therapy, including para-aminosalicylic acid and streptomycin, other than isonicotinic acid hydrazide.

The relationship of skin testing with tetrahydrofurfuryl ester of nicotinic acid to tuberculosis, isonicotinic acid hydrazide therapy, rheumatic fever and the metabolism of tryptophan and nicotinic acid have been discussed.

We acknowledge, with thanks, the cooperation of Dr. W. L. Potts, medical director, and the staff of the Southeast Florida Tuberculosis Hospital, Lantana.

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ABSTRACTS

Bilateral Facial Agenesia (Treacher Collins Syndrome). By Clifford C. Snyder, M.D. Am. J. Surg. 92:81-87 (July) 1956.

The purpose of this paper is to focus attention on a group of congenital facial anomalies which, when assembled, present a definite clinical entity. The author notes that other authors have described various parts of this syndrome with the sincere impression that they have added something new to the literature and adds that although it is the consensus of many that this complicated anomaly is a rare disease, it has been found to be more common than previously believed. He regards this misunderstanding as possibly due to the various names attached to the syndrome. He describes the complex clinical picture of bilateral facial agenesia and various corrective surgical procedures. Patients with the deformities associated with this syndrome have normal intelligence and deserve the surgical reconstruction which he advocates.

Cervical Cancer: Chronic Inflammation, Stress and Adaptation Factors. By J. Ernest Ayre, M.D. Acta Union Internationale Contre Le Cancer 12:20-26, 1956.

In the quest for an understandable concept of carcinogenesis there has long been speculation regarding the role of chronic inflammation in the production of carcinoma of the cervix. The clinical and epidemiologic factors here presented substantiate the concept that chronic cervicitis and cancer are related. An hypothesis is introduced suggesting that Selye's stress and adaptation syndrome may fit into the picture of cervical carcinogenesis. The leukorrhea of chronic cervicitis, the presence of an estrogen in cervical mucus, and hypoxia resulting from the fibrotic changes of chronic inflammation are presented as "links" in a "chain reaction" of cancergenesis. A promising avenue for further research into this complex problem is suggested.

Nuclear Size and Nuclear: Cytoplasmic Ratio in the Delineation of Atypical Hyperplasia of the Uterine Cervix. By Alvan G. Foraker, M.D., and James W. Reagan, M.D. Cancer 9:470-479 (May-June) 1956.

The present study is an attempt to orient atypical hyperplasia as regards nuclear size and nuclear:cytoplasmic ratio with respect to obviously innocuous squamous metaplasia and to intraepithelial carcinoma. Nuclear size and nuclear:cytoplasmic ratio in atypical hyperplasia and intraepithelial carcinoma of the uterine cervix were subjected to measurement and comparison. Nuclear measurements on normal and abnormal epithelium from 20 cases each of intraepithelial carcinoma, atypical hyperplasia, and squamous metaplasia were prepared. The results showed (1) little difference in nuclear measurement properties of normal epithelium from all three types of cases; (2) similar mean nuclear size in all epithelial layers, and similar nuclear:cytoplasmic ratio in the basal layers of intraepithelial carcinoma and atypical hyperplasia; (3) progressively higher nuclear:cytoplasmic ratio in the middle layer of epithelium in metaplasia, atypical hyperplasia, and intraepithelial carcinoma; and (4) evidence of more cell

maturation through the layers of atypical hyperplasia than in those of intraepithelial carcinoma.

With respect to the sum of these nuclear measurement properties, atypical hyperplasia occupied an intermediate position between metaplasia and intraepithelial carcinoma. This intermediate position corresponds to the relationships of the general microscopic pattern of these three entities, as well as to their apparent biologic significance in the production of invasive squamous carcinoma of the uterine cervix.

Squamous Cell Carcinoma of the Anus: A Case Report. By R. Sam Mosely, M.D. South. M. J. 49:1006-1010 (Sept.) 1956.

Squamous cell carcinoma of the anus represents less than 2 per cent of the tumors of the intestinal tract. In this article the literature is reviewed, and a case is reported. This lesion is insidious in onset and, as in the case here described, may be asymptomatic for several years. The author suggests that all tumor masses in the anal area should be suspected and subjected to biopsy. Extension is usually by contiguity, but there may be spread through the lymphatic pathways and rarely through the blood stream. Less than 10 per cent of the reported cases had spread to the inguinal lymph nodes. Whereas irradiation used to have a prominent place in the treatment of these lesions, most of the surgeons in the larger medical centers now are of the opinion that early radical surgery is better. Irradiation may cause the loss of valuable time in the treatment of this tumor. The combined abdominoperineal resection is considered the operation of choice, and only rarely is local excision indicated. Routine excision of the inguinal glands is of doubtful value. Although the present five year survival rate for this tumor compares favorably with that of adenocarcinoma of the rectum, this should be improved with a greater use of radical surgery.

Anomalous Type of Salt and Water Retention with Persistent Edema; Report of a Case. By Leonard G. Rowntree, M.D., Robert J. Boucek, M.D., and Nancy L. Noble, Ph.D. J. A. M. A. 161:877-879 (June 30) 1956.

The effect of the central nervous system upon salt and water metabolism is being noted more frequently, particularly as a postoperative neurosurgical complication. For three years the authors have had the opportunity of studying a case of apparent postencephalitic involvement of the central nervous system affecting salt and water metabolism, presumably through the neurohypophysis. It is the purpose of this report to review the pertinent features of the clinical and laboratory records of this patient and the record of the diuretic response to various agents and to suggest the possible mechanism of the salt and water retention. The patient has an anomalous type of edema that developed six months after a second attack of encephalitis, has persisted over seven years in spite of dietary salt restriction, and requires weekly use of diuretics. The red blood cells reveal an exaggerated sodium and potassium response to augmented sodium intake and to diuretics. The authors presume that the syndrome is neurohormonal in origin and may represent the antithesis of diabetes insipidus — and possibly a form of "hyperpitressinism."

Value of Cytology in the Accidents of Early Pregnancy: Preliminary Report. By Wayne S. Rogers, M.D., J. Ernest Ayre, M.D., and Kola M. Kennedy. Obst. & Gynec. 8:437-443 (Oct.) 1956.

In a series of 122 consecutive patients, routine cytologic examination was made during their first antepartum visit in an attempt to detect endocrine dysfunction. Of those experiencing clinically normal pregnancies, 11 per cent showed an endocrine deficiency, and of those with clinically threatened abortion, 54.8 per cent had evidence of a deficiency. Those patients who were clinically normal and whose cytologic examination revealed an endocrine dysfunction were placed in categories of cytologic threatened abortions and cytologic missed abortions.

It was suggested that the cytologic findings may be used as a method of standardization of the patients for the evaluation of the various methods of treatment. It was also observed that the question of pathologic ova may be better evaluated when the response to therapy is studied in those patients showing minimal deficiencies.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

Volume XLIV
Number 2

President's Page

Hopeful Procrastination

Are we in a state of hopeful procrastination? Yes, I am afraid we are. As I sit here in the wee hours of the morning on well developed gluteus maximus muscles, I am perfectly content to wait out the process of childbirth, an attitude which is considered one attribute of a good obstetrician. Waiting for nature to take its course without having to use but little more brains and skill than the average good midwife is nothing more than hopeful procrastination.

Awake and alert, I am aiding nature when I can and should, like a well trained obstetrician is expected to do, even if there is need for nothing more than boosting morale and allaying fear. I am like too many of our doctors in the Florida Medical Association, just willing to let nature take its course with the hope that all will be well when the contest is finished. Should something go wrong with nature, however, and it begins to play tricks on me and my patient, then I am expected to be willing and able to cope with its wrongdoings.

Likewise, with all kinds of unnatural tricks from many unnatural sources being forced upon organized medicine today, too many of us are willing to resort to Hopeful Procrastination. Doing nothing individually or collectively toward combating the evil forces that beset us, in the hope they will reconcile themselves, is really abusing the old glutei. It is high time we gave them a rest and used our brains and skill to decompose, dissolve, destroy or deter those tricks, trades and tyrants that seek to decompose, dissolve, or deter our freedom and our way of life as doctors of medicine.

Yes, it is time for real thinking and action individually and collectively, for hopeful procrastination is not going to reconcile or protect our freedom or our profession. Our holding action against these vipers must be turned into a potent and powerful offensive force, for to continue to retreat, appease and pacify is not good medicine, the kind it will not do to practice.

Your House of Delegates at the recent convention of the Association took a stand. The doctors of Florida have stopped retreating. Now we must get on the offensive with real bulldog tenacity and let the rest of the country know we are potent and mean business. The eyes of the nation are now on Florida in many respects, but particularly on the Florida Medical Association.

Our most potent weapon is our state Association, and our Association's most potent weapon is the county medical societies, and the county medical societies' most potent weapon is the individual members. All these must be tightly organized. We cannot be sick, weak and disorganized; instead, we must be strong, healthy and tightly organized. The only way we will fail is to be divided among ourselves. This must never be.

Let us get off our glutei, attend our society meetings and take an active part. Let us speak our mind, lest our thinking and actions go astray and we wonder WHO DONE IT. Let us not be victims of Hopeful Procrastination.



THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. Box 2411 Jacksonville, Florida

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Actions of the Florida Legislature 1957 Session

The legislative program of the Florida Medical Association for the 1957 session of the Florida legislature fared well. Its major objectives met a large measure of success, justifying the vast amount of time spent in determining and coordinating a sound, constructive over-all program. It was necessary to follow 65 bills introduced on a wide variety of subjects which in some way pertained to the medical profession of the state and its role in protecting the health and welfare of the public.

Naturopathy

Support of the recommendations of Governor LeRoy Collins to abolish the practice of naturopathy in Florida was the primary objective of the Association's program. After introduction of the original bill to outlaw the practice of naturopathy in the state, the supporters of this measure deemed it advisable to accept a committee substitute which accomplished the following:

1.—Redefined naturopathy by excluding phytotherapy and biochemistry from the list of authorized means of practicing naturopathy and specifically prohibited a naturopath from prescribing or administering any drugs.

2.—Abolished the Board of Naturopathic Examiners and placed all their present authority under the State Board of Health.

3.—Revoked all nonresident licenses and allowed only those naturopaths to continue who had been in active practice in the State of Florida for two years.

4.—Provided that all naturopaths who are authorized to continue to practice be recertified by the State Board of Health.

This bill passed the House without amendments, but was amended in the Senate to exclude those naturopaths who had been practicing for 15 years in Florida and permit them to administer narcotics in cases of emergency justifying their use. The House concurred in the Senate amendment, and the Governor signed the bill into law on May 16, 1957. It becomes effective on October 1 of this year.

A bill to allow veterans of military service or those receiving their training under the G. I. bill to be considered as having practiced naturopathy in Florida for 15 years, thereby qualifying them for drug privileges, was introduced and supported by the naturopaths. This bill was amended to provide that they must have served in the Armed Forces during World War II as naturopathic physicians or must have received their naturopathic training under the G. I. bill. Passed by both Houses, the bill was vetoed by the Governor on June 28, 1957, and therefore did not become law.

"I am confident," said Governor Collins, commenting on the naturopathy legislation, "that this new law will prove of great public benefit. For many years and for many sessions, efforts have been made in Florida to eliminate abuses in this field, but this is the first time that substantial progress has been made."

Indigent Hospitalization Program

A second major objective of the Association was to support the budget request of the State Board of Health for $4,000,000 for the 1957-1959 biennium for its Hospital Service for the Indigent Program. The full amount was appropriated by the legislature to match county funds for hospitalization of acutely ill or injured indigent persons. No provision, however, was made by the lawmakers for funds to continue the program of the State Welfare Board for hospitalization of public welfare recipients.

Other Association-Supported New Laws

Upon the recommendation of the Florida Orthopedic Society, the Association supported amendments to the Physical Therapy Law. Among the provisions was a grandfather clause to allow registration of certain physical therapists who were not graduates of approved schools, but who had certain qualifications acceptable to the State Board of Medical Examiners.

The entire amount requested by the State Board of Health to continue 10 medical student scholarships was granted. The sum of $70,000 was appropriated for this purpose.

The budget request of the State Board of Health for the purchase of Salk polio vaccine for indigents was granted. The amount appropriated was $250,000.

Additional Legislation Enacted

Among the numerous other measures of interest to Association members, a few deserve mention in this brief résumé of legislative action. The Mandatory Hospital Licensing Law was sponsored by the Florida Hospital Association. It provides for the definition of a hospital and licensure by the State Board of Health.

Amendments to the Florida Pharmacy Act were sponsored by the Florida Pharmaceutical Association. One change was removal of the provision for the preparing, compounding and dispensing of drugs by persons other than physicians under a physician's direct supervision. The law still provides that a physician may compound, prepare and dispense drugs provided he himself does so.

A law was enacted defining psychology and providing for the certification of psychologists. It is known as the Psychologists Certification Act.

Statutory revisions were made which strengthen the power of the Osteopathic and Chiropractic Boards to control the persons under their jurisdiction.

Taking effect immediately upon its approval by the Governor on June 3, an act was passed granting the state attorney or the county solicitor the power, at his discretion, to have autopsies performed upon dead bodies found within the county, either before interment or after interment, whenever, in his opinion, such autopsies are necessary in order to ascertain whether or not death was criminally caused.

Membership Cooperation

The Association's Committee on Legislation and Public Policy, with Dr. H. Phillip Hampton as chairman, and the Association's Executive Office, with Mr. W. Harold Parham, Assistant Managing Director, who represented the Association in Tallahassee during the entire session, deserve the plaudits of the membership for their tireless efforts in behalf of constructive legislation for the protection of the health and welfare of Floridians. Supporting them were the component county societies and their officials, who laid the ground work for the success of the program adopted. It is noteworthy that approximately half of the county medical societies had representatives at the public hearing held by the Senate and House Public Health Committees to consider the naturopathy bill. Ably assisting Dr. Hampton in expressing the Association's position on that occasion were Dr. Edward R. Annis of Miami and the Association's Secretary-Treasurer, Dr. Samuel M. Day of Jacksonville. The officers of the As-

sociation, and particularly Dr. Edward Jelks, gave unstintingly of their time and effort to promote the entire legislative program. The degree of cooperation and support given the Association leaders by the membership in large measure also determined the success of the program and set an excellent example of teamwork within the Association.

Florida Medicine and the Future

A close look at a recent membership study of the Florida Medical Association in relation to future growth points up the need for injecting long range planning into the Association's programs, activities and services. Thinking along this line in a big way is in order.

Florida is growing at a faster rate than any state in the union except for two small thinly populated Western states. Since the first of 1950, the number of persons moving into Florida each week to establish permanent homes has averaged 2,614. This figure is based on an estimate of 3,800,000 residents in the state in 1955, representing a 43.7 per cent increase since 1950. With resident births in excess of resident deaths by 927 weekly, this latest available report[1] indicates that Florida's population growth is now averaging 3,568 weekly. Between 1940 and 1955, the population figures practically doubled, with a net increase of 43.7 per cent. Estimates of future population mount to 4,960,000 by 1962 and 6,100,000 by 1967.

Growth of membership in the Association presents an interesting parallel. Members numbered 1,370 in 1940 and 2,743 in 1955, almost an exact doubling of the figures, but representing a net increase of 711 members, or 39.9 per cent. The net increase in the two years that have elapsed since that time is 326 members, or 11.9 per cent. The average yearly net increase in membership for the last five years (1953-1957) has been 157.

The long look ahead indicates that on reliable estimates of population growth and growth in membership of the Association, there will be 3,854 members in 1962 and 4,639 members in 1967, whereas, on the basis of one physician for every thousand residents of the state, there will be need for 4,960 physicians in 1962 and 6,100 in 1967. It appears that with the new medical schools, the number of physicians coming from other states and the Association's placement service to aid in the placing and equitable distribution of new physicians, the need will be met.

What will living be like 25 years from now? The magazine, "Changing Times," assumed the prophetic role recently by answering that question in an article entitled "Look 25 Years Ahead — Great Changes Coming," touching on almost every phase of life. Under the subhead, "Health," the article said: "Medical bills will be paid for in advance, through insurance and prepaid plans. But it doesn't look as if compulsory health insurance under government auspices is in the cards." If the magazine proves a true prophet and that specter is out of the way, Florida medicine may look forward to a particularly bright future if it shoulders its responsibility now and plans wisely for the challenge that lies ahead.

1. Directory of Florida Industries, 1956-1957 Edition, published by the Florida State Chamber of Commerce, Jacksonville.

"Heedless Horsepower"

A new deadly disease has the American people in its grip, and no miracle drug is in sight to stop its frightful toll of human lives.

Heedless horsepower is the chronic disease of the Age of the Automobile. Its symptoms are many and various. The heavy foot on the accelerator; the eye fixed on the climbing speedometer; the hand on the horn; the mind idling while the car is in high.

In its twenty-third annual highway safety publication, "Heedless Horsepower," The Travelers Insurance Companies of Hartford, Conn., point to the fact that 40,000 Americans were killed and 2,368,000 injured in 1956 on the nation's highways. That is an increase of 6 per cent in fatalities and nearly 10 per cent in injuries over 1955's total.

"The disease of heedless horsepower is highly contagious," the booklet states. It can be spread by an irresponsible word, an inflated claim, a careless example. Everyone who is in a position to influence drivers should learn that horsepower, in the hands of the heedless, is the fundamental cause of the ever mounting toll of disaster.

In recent years, engineers have made many attempts to feature safety equipment in the new cars. Probably many lives have been spared by safety glass, seat belts, padded instrument panels, all-steel bodies, and other protective measures. Nevertheless, these safety devices can be nullified

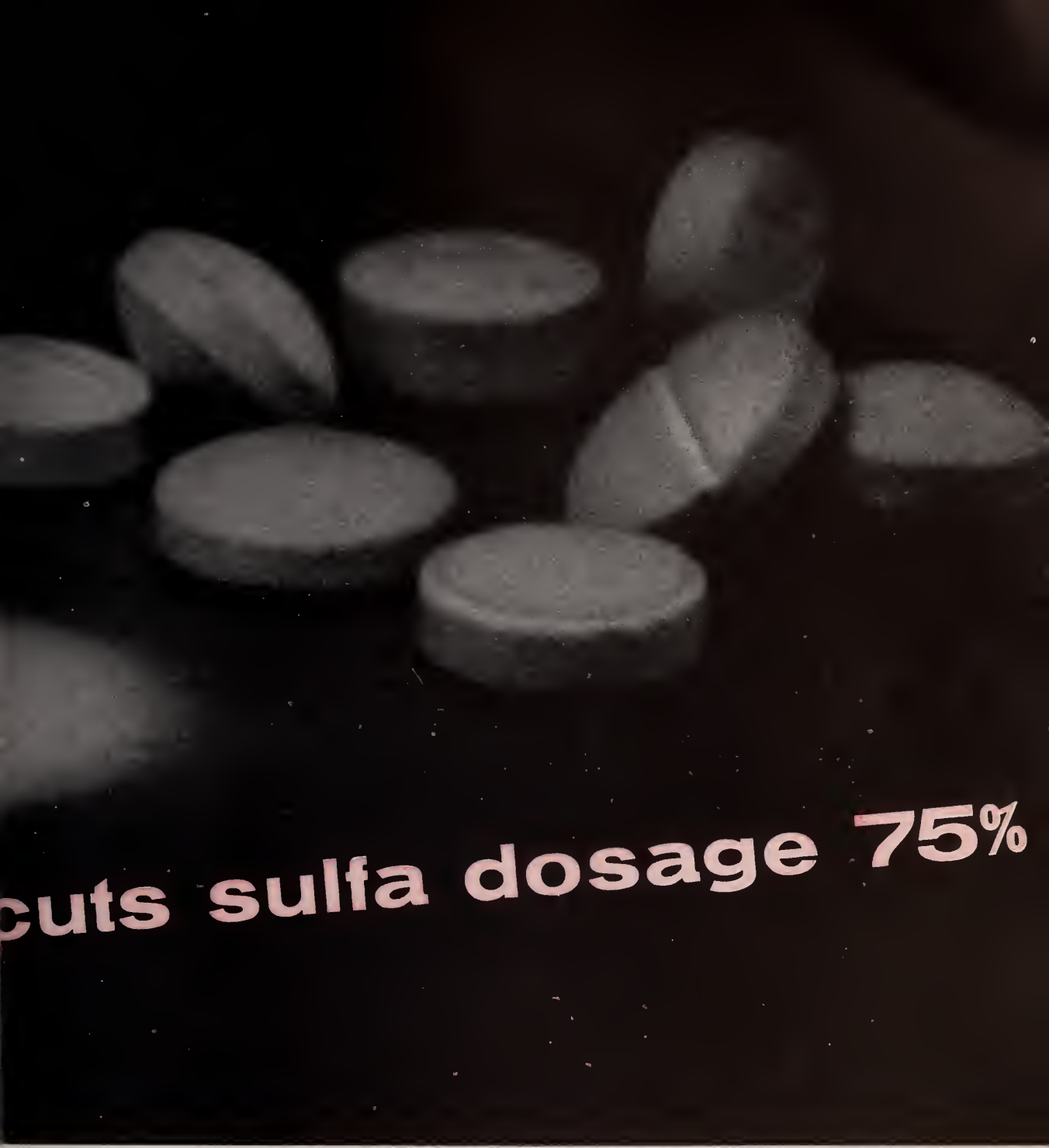
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greater safety—high solubility, slow excretion and low dosage help avoid crystalluria. No increase in dosage is recommended; the usual precautions regarding sulfonamides should be observed.

convenience—the low maintenance dosage of 1 Gm. (2 tablets) per day for the average adult offers optimal convenience and acceptance to patients.

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syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

(1) Boger, W. P.; Strickland, C. S. and Gylfe, J. M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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by any combination of speed plus carelessness, thoughtlessness or lack of judgment by the driver behind the wheel.

It is the driver, however, not the manufacturer, the advertiser or the salesman, who must bear the greatest weight of blame, for it is the driver who can control the horsepower and use it safely for his greater ease and convenience. It is the driver who is lectured to, legislated at, prayed for, preached to — in every medium of public expression known to man. It is likewise the driver who nods sagely, promises readily, and forgets everything but his sense of overwhelming power when he steps on the gas.

Casualty lists on the highways have mounted steadily until in 1956 all records of heedless haste and needless waste were shamefully broken. The facts of human suffering and death speak for themselves.

Human error is by far the biggest single cause of accidents. Figures compiled by The Travelers show that in 96.4 per cent of the fatal crashes last year, the automobile was in apparently good condition. Clear, dry weather prevailed in more than 85 per cent of these instances.

If this year's record is equal to that of 1956, one in 70 Americans will be a statistic — a pain-wracked survivor, or a name in the obituary column.

The Florida Medical Association is alert to its role in helping to meet this national problem. Its Medical Advisory Committee to the Florida Department of Public Safety is making a notable contribution in discharging its duties. At the Association's recent annual meeting, a resolution, presented by the Pinellas County Medical Society, was adopted committing the Association to urge the American Medical Association, which has long been working on the problem, to lead the way in establishing minimum standards of physical, mental and psychological ability for the safe operation of motor vehicles.

Especially noteworthy also is the bill for compulsory minimum safety standards for automobiles introduced in the House of Representatives by Congressman Bennett of Florida. These standards would include speed capacity, safety padding, steering control, lights, visibility aids and other equipment. He recently told the House Interstate subcommittee holding hearings on traffic safety problems that it was "totally unrealistic to expect effective self-regulation in this field, despite the obvious desire of most manufacturers to make their products safe." The American Medical Association was scheduled to testify soon before this subcommittee.

Graduate Medical Education Hematology Seminar and Short Course Held

The Seminar on Hematology, held June 20-22 at the College of Medicine of the University of Florida in Gainesville, was exceptional. The attendance was fair for so highly specialized a course and comparable to the previous registrations. The lecturers were noteworthy because of their practical and informative approach to the subject, both for the pathologists and the physicians specializing in hematology. In view of the increased interest in this specialty, presentation of this subject will doubtless receive particular consideration in future planning.

Dr. Steven O. Schwartz, Associate Professor of Medicine at Northwestern University School of Medicine, was particularly well received. His methods of teaching proved to be most helpful to those not specializing in hematology. The physicians of Florida who lectured deserve commendation for their excellent presentations.

The lectures of the Twenty-Fifth Annual Graduate Short Course, also held at the College of Medicine on June 24-28, immediately following the Seminar, were received with the usual close attention and enthusiasm. The attendance, however, was less than in previous years. This decrease was attributed to the fact that the Course was held in a small city where the group of local physicians is small. When the University Hospital is completed and operating, the presenting of graduate medical education will be much easier, and probably the physicians can more profitably spend their time while in attendance.

The physicians present manifested genuine pleasure at having Drs. James V. Warren, Howard W. Jones, and Georgeanna S. Jones return for these lectures. Dr. James R. Cantrell of The Johns Hopkins University School of Medicine, who gave the lectures on Surgery, made a most satisfactory presentation. One of the outstanding features in both the Seminar on Hematology and the Short Course was the contribution made by the College of Medicine of the University of Florida. The faculty presented highly specialized subjects, in each instance making them most profitable to the practicing physician.

Report of Florida Delegates to American Medical Association 1957 Annual Meeting

Revision of the Principles of Medical Ethics, relations with the United Mine Workers of America Welfare and Retirement Fund, the federal government's Medicare program, new standards for medical schools, a new statement on occupational health programs and the issue of Social Security benefits for physicians were among the wide variety of subjects acted upon by the House of Delegates at the American Medical Association's 106th Annual Meeting held June 3 to 7 in New York City.

Dr. Gunnar Gundersen of La Crosse, Wis., member of the A.M.A. Board of Trustees since 1948 and chairman for the past two years, was unanimously chosen president-elect for the year ahead. Dr. Gundersen, who also was first chairman of the Joint Commission on Accreditation of Hospitals from 1951 to 1953, will become president of the American Medical Association at the June 1958 meeting in San Francisco. There he will succeed Dr. David B. Allman of Atlantic City, N. J., who became the 111th president at the Tuesday night inaugural ceremony in the Grand Ballroom of the Waldorf-Astoria Hotel.

The House of Delegates voted the 1957 Distinguished Service Award of the American Medical Association to Dr. Tom Douglas Spies, head of the department of nutrition and metabolism at Northwestern University Medical School, Chicago, and director of the nutrition clinic at Hillman Hospital, Birmingham, Ala., for his outstanding contributions to the science of human nutrition. For only the third time in A.M.A. history, the House also voted a special citation to a layman for outstanding service in advancing the ideals of medicine and contributing to the public welfare. Recipient of this award was Henry Viscardi Jr., of West Hempstead, N. Y., founder and president of Abilities, Inc., which employs only severely disabled persons.

Physician registration at the New York meeting had already reached an all-time high at 5 p.m. Thursday with 18,982 counted and scores of registration cards still unprocessed. The previous high was chalked up at the 1953 New York meeting when the five day total was 17,958 physicians.

New Principles of Medical Ethics

The House approved the long-discussed revision of the Principles of Medical Ethics, originally submitted at the 1956 annual meeting in Chicago. The final version, presented by the Council on Constitution and Bylaws and then amended by reference committee and House discussions in New York, now reads as follows:

Principles of Medical Ethics

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physican may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

In approving the new Principles of Medical Ethics, the House of Delegates also reaffirmed the "Guides for Conduct for Physicians in Relationships with Institutions," adopted in 1951, and requested the Board of Trustees to devise and initiate a campaign to educate both physicians and the general public to the dangers inherent in the illegal corporate practice of medicine in its various forms.

Guides for Relations with UMWA Fund

In a key action on the basic issue of third party intervention, as it affects the patient's free choice of physician and the physician's method of remuneration, the House adopted the "Suggested Guides to Relationships Between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund." which were submitted by the A.M.A. Committee on Medical Care for Industrial Workers. In approving the guides, the House also recommended that the Board of Trustees study the feasibility and possibility of setting up similar guides for relations with other third party groups such as management and labor union plans.

The statement, which outlines both medical society and UMWA responsibilities, contains these "General Guides:"

"1. All persons, including the beneficiaries of a third-party medical program such as the UMWA Fund, should have available to them good medical care and should be free to select their own physicians from among those willing and able to render such service.

"2. Free choice of physician and hospital by the patient should be preserved:

"a. Every physician duly licensed by the state to practice medicine and surgery should be assumed at the outset to be competent in the field in which he claims to be, unless considered otherwise by his peers.

"b. A physician should accept only such terms or conditions for dispensing his services as will insure his free and complete exercise of independent medical judgment and skill, insure the quality of medical care, and avoid the exploitation of his services for financial profit.

"c. The medical profession does not concede to a third party such as the UMWA Welfare and Retirement Fund in a medical care program the prerogative of passing judgment on the treatment rendered by physicians, including the necessity of hospitalization, length of stay, and the like.

"3. A fee-for-service method of payment for physicians should be maintained except under unusual circumstances. These unusual circumstances shall be determined to exist only after a conference of the liaison committee and representatives of the Fund.

"4. The qualifications of physicians to be on the hospital staff and membership on the hospital staffs is to be determined solely by local hospital staffs and by local governing boards of hospitals."

The Medicare Program

The House considered three resolutions dealing with the federal government's Medicare program for the dependents of servicemen. The delegates adopted one resolution condemning any payments under the Medicare program "to or on behalf of any resident, fellow, intern or other house officer in similar status who is participating in a training program." Government sanction of such payments, the House declared, would give impetus to the improper corporate practice of medicine by hospitals or other nonmedical bodies. Such proposals, the House added, would violate traditional patterns of American medical practices, seriously aggravate problems of hospital-physician relationships, encourage charges by hospitals for residents' services to patients not under the Medicare program, and create a variety of additional problems in such areas as medical licensure and health insurance.

In another action on Medicare, the House recommended that the decision on type of contract and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination. In this connection, however, the House restated the A.M.A. contention that: the Dependent Medical Care Act as enacted by the Congress does not require fixed fee schedules; the establishment of such schedules would be more expensive than permitting physicians to charge their normal fees, and fixed fee schedules would ultimately disrupt the economics of medical practice.

The House also suggested that the A.M.A. attempt to have existing Medicare regulations amended to incorporate the Association's policy that the practice of anesthesiology, pathology, radiology and physical medicine constitutes the

practice of medicine, and that fees for services by physicians in these specialties should be paid to the physician rendering the services.

New Statement on Medical Schools

To replace the "Essentials of an Acceptable Medical School," initially approved by the House of Delegates in 1910 and most recently revised in 1951, the House adopted a new statement entitled "Functions and Structure of a Modern Medical School." Presentation of the document followed a year of careful study by the Council on Medical Education and Hospitals in collaboration with the Association of American Medical Colleges.

The statement is intended to provide flexible guides which will "assist in attaining medical education of ever higher standards" and "serve as general but not specific criteria in the medical school accreditation program." The document encourages soundly conceived experimentation in medical education, and it discourages excessive concern with standardization.

"No rigid curriculum can be prescribed for accomplishing the objectives of medical education," it states. "On the contrary, it is the responsibility of the faculty of each school continually to re-evaluate its curriculum and to provide in accordance with its own particular setting and in recognition of advances in science a sound and well-integrated educational program."

Occupational Health Programs

The House also approved a new statement on the "Scope, Objectives and Functions of Occupational Health Programs," submitted through the Board of Trustees by the Council on Industrial Health. The Board report to the House said: "The statement describes and defines orthodox in-plant medical programs as understood in this country today and distinguishes clearly between such programs and the various plans for comprehensive medical care of the sick. It should help to resolve misunderstandings concerning the specialty of occupational medicine."

In adopting the statement, the House agreed with a reference committee report which declared that "the House has before it a statement which for the first time clearly defines the scope, objectives and functions of occupational health programs. It marks the needs and boundaries of occupational medicine. It states in a positive fashion the proper place of occupational health programs in the practice of medicine and it clearly charts the pathways of communication between physicians in occupational health programs and physicians in the private practice of medicine."

Social Security for Doctors

Two resolutions favoring compulsory inclusion of physicians in the federal Social Security system and another one calling for a nationwide referendum of A.M.A. members on the issue were rejected by the House. The delegates reaffirmed their opposition to compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act. They also recommended a strongly stepped-up informational program of education which will reach every member of the Association, explaining the reasons underlying the position of the House of Delegates on this issue. The House at the same time reaffirmed its support of the Jenkins-Keogh Bills.

Miscellaneous Actions

In considering 66 resolutions and many additional reports from the Board of Trustees, councils and committees, the House also:

Congratulated the Board and the Committee on Poliomyelitis for their prompt action in stimulating national interest in the polio immunization program;

Recommended further study and a progressive program of action, probably including legislative changes, to solve the problem of narcotic addiction;

Urged a more careful screening of television and radio patent medicine advertisements;

Directed the Board of Trustees to investigate the indiscriminate use of stimulants such as amphetamine, particularly in relation to athletic programs;

Directed the Speaker to appoint a committee of five House members to study the Heller Report, a management survey of the Association's organizational mechanisms;

Commended the Law Department for its special report on professional liability and urged state and county medical societies to establish claims prevention programs and to show the new film, "The Doctor Defendant;"

Opposed the establishment of any further veterans' facilities for the care of non-service-connected illnesses of veterans;

Condemned the compulsory assessment of

medical men and staff members by hospitals in fund-raising campaigns;

Commended the television program, *Dr. Hudson's Secret Journal,* its producers and its star, Mr. John Howard, for an outstanding contribution to the public interest and welfare, and

Recommended payment of transportation expenses of Section Secretaries for A.M.A. meetings which they are required to attend.

Opening Session

At the Monday opening session Dr. Dwight Murray, retiring A.M.A. president, stressed the triple theme of the personal touch in medicine, the necessity for freedom in medical practice and the need for professional unity. Dr. Allman, then president-elect, warned against the dangers of third party contractural agreements involving fixed fee schedules. The Goldberger Award in nutrition research was presented to Dr. Paul Gyorgy of Philadelphia. An A.M.A. citation was awarded to the Parke-Davis & Company for its continuing series of institutional advertisements telling the story of medicine and medical progress. Dr. H. G. Weiskotten, who retired after many years as chairman of the Council on Medical Education and Hospitals, received two bound volumes of letters of appreciation and also an ovation from the House of Delegates.

Inaugural Ceremony

Dr. Allman, in his Tuesday night inaugural address, declared that the physician is constantly striving for a balance between personal, human values, scientific realities and the inevitabilities of God's will. The inaugural ceremony, which was telecast over Station WABD-TV in New York, included presentation of the Distinguished Service Award to Dr. Spies and the special layman's citation to Mr. Viscardi. Also taking part in the program was the United States Army Chorus of Washington, D. C.

Election of Officers

In addition to Dr. Gundersen, the new president-elect, the following officers were selected by the House on Thursday:

Dr. Jesse Hamer of Phoenix, Ariz., vice president; Dr. George F. Lull of Chicago, secretary; Dr. J. J. Moore of Chicago, treasurer; Dr. E. Vincent Askey of Los Angeles, speaker, and Dr. Louis Orr of Orlando, Fla., vice speaker.

Four new members were elected to the Board of Trustees: Dr. George Fister of Ogden, Utah, to succeed Dr. James R. Reuling; Dr. Cleon Nafe of Indianapolis, Ind., to succeed Dr. James R. McVay; Dr. James Z. Appel of Lancaster, Pa., to replace the late Dr. Thomas P. Murdock, and Dr. Raymond McKeown of Coos Bay, Ore., to replace Dr. Gundersen. Dr. Edwin S. Hamilton of Kankakee, Ill., was elected chairman of the Board at its organizational meeting after the elections in the House.

Dr. Homer L. Pearson Jr. of Coral Gables, Fla., was renamed to the Judicial Council. Two new members were elected to the Council on Medical Education and Hospitals: Dr. Clark Wescoe of Lawrence, Kan., to succeed Dr. Weiskotten, and Dr. Warde B. Allan of Baltimore, Md., to succeed Dr. F. D. Murphey of Lawrence, Kan.

For the Council on Medical Service, Dr. Robert L. Novy of Detroit, Mich., was re-elected, and Dr. Hoyt Woolley of Idaho Falls, Ida., was chosen to replace Dr. McKeown. Dr. Warren W. Furey of Chicago was re-elected to the Council on Constitution and Bylaws.

At the Wednesday session of the House the Illinois State Medical Society made a record state society contribution to the American Medical Education Foundation by turning over $170,450 to Dr. Louis H. Bauer of New York, foundation president.

Respectfully submitted,
Louis M. Orr, M.D.
Reuben B. Chrisman Jr., MD.
Francis T. Holland, M.D.

Registration

Total registration of Florida Medical Association members at the 1957 A. M. A. annual meeting in New York was 159. Members in attendance were:

BELLE GLADE: Wilbert O. Norville (Col.). BRADENTON: Lowrie W. Blake, Roy W. Gunther, Willis W. Harris, Richard V. Meaney. CLEARWATER: Lewis A. Gryte, Robert P. Vomacka. CORAL GABLES: Donald H. Altman, W. A. D. Anderson, A. Daniel Amerise, Reuben B. Chrisman Jr., Glenn H. Heller, C. Howard McDevitt, Wesley S. Nock, Frederick P. Poppe, Joseph H. Rudnick, George F. Schmitt Jr., Louis C. Skinner Jr., William L. Wagener Jr., CRYSTAL RIVER: Samuel R. Miller Jr. DADE CITY: Dwayne L. Deal. DANIA: Fred E. Brammer. DAYTONA BEACH: Cleland D. Cochrane, J. Richard West. DELAND: Matthew A. Moroz. FORT LAUDERDALE: Burns A. Dobbins Jr., Richard A. Mills, George T. F. Rahilly, Scottie J. Wilson.

FORT MYERS: James B. Schutt. GAINESVILLE: Edwin H. Andrews, George T. Harrell Jr. HIALEAH: Van M. Browne, Albert W. McCorkle. HOLLYWOOD: Selig J. Bascove, Bertram J. Frankel, Louis J. Novak, Sidney J. Peck, Randall W. Snow. INDIAN ROCKS: Warren J. Brown. JACKSONVILLE: Lee E. Bransford, Joseph L. Chilli, Samuel M. Day, Stephen P. Gy-

land, Louis Limbaugh, Samuel S. Lombardo, Paul V. Reinartz, Richard V. Reiswig. LAKELAND: David Sloane.

LAKE WORTH: Alva L. Rowe. LEESBURG: Arthur P. Buchanan. MARIANNA: Albert E. McQuagge, Courtland D. Whitaker. MELBOURNE: Theodore J. Kaminski. MIAMI: Ernest R. Barnett, Robert C. Bartlett, Robert J. Boucek, John E. Burch, Milton M. Coplan, Victor Dabby, Carl H. Davis, Byron D. Epstein, John J. Farrell, Gus G. Casten, James H. Ferguson, Roger J. Forastiere, M. Jay Flipse, N. Stuart Gilbert, George Gittelson, Frederick A. Gunion, William C. Hutchison, Morris Jaffe, Arnold L. Kane, Solomon Kann, Harold S. Kaufman, Alexander Kushner, George D. Lilly, Ronald J. Mann, Stanley Margoshes, E. Sterling Nichol, Raymond E. Parks, Homer L. Pearson Jr., Max Pepper, Benton B. Perry, Ralph L. Pipes, Gerard Raap, Lyle W. Russell, Walter W. Sackett Jr., Ralph S. Sappenfield, J. Graham Smith, Donald G. Stannus, Arthur W. Wood Jr. MIAMI BEACH: Jack J. Falk, Eli Galitz, Jacob A. Glassman, Ralph E. Kirsch, Irwin H. Makovsky, Marvin L. Meitus, Julius R. Pearson, David K. Pinks, Charles B. Wigderson.

ORANGE PARK: Marcus B. Bergh. ORLANDO: Williard H. Boardman, J. Rocher Chappell, George W. Edwards II, Edward T. Furey, Eugene L. Jewett, Duncan T. McEwan, Louis M. Orr, Charles R. Sias. PALM BEACH: Alvin E. Murphy. PENSACOLA: Arthur J. Butt, Vernon L. Smith. PUNTA GORDA: Robert H. Shedd. ROCKLEDGE: John C. Miethke. ST. AUGUSTINE: Vernon A. Lockwood. ST. PETERSBURG: Arnold S. Anderson, Elmer B. Campbell, Paul T. Cope, Charles K. Donegan, Robert M. Kilmark, James K. McCorkle, Norval M. Marr Jr., John R. Neefe, William B. Norris, Richard Reeser Jr., Joseph S. Spoto. SARASOTA: George M. Coggan, Linwood M. Gable, Melvin M. Simmons, Henry J. Vomacka. TALLAHASSEE: Edson A. Andrews, James K. Conn, Francis T. Holland. TAMPA: Frank S. Adamo, Joseph D. Brown, Richard G. Connar, Stephen P. Gyland, H. Phillip Hampton, A.M.C. Jobson, Eunice M. Lasche, Alford F. Massaro, Hugh E. Parsons, Mason C. Smith, Wesley W. Wilson. VERO BEACH: Vernon L. Fromang, John P. Gifford, James C. Robertson. WEST PALM BEACH: Robert V. Artola, John M. Baber, Matthew N. DePasquale, Ralph M. Overstreet Jr., Raymond R. Preffer, James C. White. WILDWOOD: Philip Stutsman. WINTER HAVEN: Chester L. Nayfield, Wiley T. Simpson. WINTER PARK: Ruth S. Jewett, Russell W. Ramsey.

Southern Medical Association Builds Permanent Headquarters

The Southern Medical Association is to be congratulated on attaining the goal of a permanent home in this first year of its second half century of existence. The project is now well under way, and the building is expected to be completed before the year is out.

The handsome, modernistic edifice will become the focal point for the association's 10,000 members in 16 states, the District of Columbia, Puerto Rico and the Canal Zone. It will stand as tangible evidence of the remarkable growth and outstanding contribution made by this organization, on a regional basis, to the progress of medicine generally and particularly to its advancement in the South.

Birmingham, which has been headquarters of the association for 41 of its 50 years, now becomes its permanent home. Consideration was also given to Atlanta, Memphis and Nashville. The split-level structure, which will house the executive offices and also the Southern Medical Journal, is being erected on a tract of nearly an acre located on Birmingham's famed Highland Avenue in a select area in the southeast section of the city. The site is near the Medical Center.

The building and site will represent an investment of $175,000, of which $50,000 is land cost. Representing Florida on the Home Building Finance Committee is Dr. Walter C. Jones of Miami. Dr. Jones is a past president of the Southern Medical Association.

Postgraduate Obstetric-Pediatric Seminar

(Formerly Tri-State Obstetric Seminar)
Daytona Beach, Sept. 9-11, 1957

All physicians are cordially invited to attend the Postgraduate Obstetric-Pediatric Seminar at the Daytona Plaza Hotel in Daytona Beach on September 9, 10 and 11. The program will be especially attractive to pediatricians, obstetricians and general practitioners. There is no registration fee. The faculty will consist of out-of-state specialists in the fields relating to maternal and child health.

Plans for the program are rapidly nearing completion and tentative programs will be mailed out as soon as they are available.

The meeting is jointly sponsored by the Bureau of Maternal and Child Health of the State Health Departments of Florida, Georgia, South Carolina and Alabama, and the Maternal Welfare Committees of the four State Medical Associations. It is approved by the Academy of General Practice in Category II.

Medical District Meetings

Dr. S. Carnes Harvard, of Brooksville, Chairman of the Council of the Florida Medical Association, has announced that the 1957 Medical District Meetings will be held the last four days of October—in Panama City, Oct. 28; in Clearwater, Oct. 29; in Orlando, Oct. 30, and in Fort Pierce, Oct. 31.

Dr. Harvard and his district councilors are arranging an outstanding scientific program.

STATE BOARD OF HEALTH

A New Strain of Influenza

Beginning in April 1957, reports of widespread outbreaks of influenza began to appear from several Far Eastern countries including India, Japan, the Philippines and Formosa. The symptoms were those of typical flu with headache, general myalgia and prostration with temperatures up to 103 F. for three to five days. Although as high as 15 per cent of exposed populations were attacked, mortality rates were extremely low. In Australia, the incidence in children under five years of age was particularly high. Laboratory studies have shown that the etiologic agent is a new antigenic strain of Type A influenza virus. This is of practical importance since widespread susceptibility to this new strain is anticipated in the United States and none of the presently available influenza vaccines confer protection against this strain of virus.

Physicians and health officials of Florida are being asked to assist the U. S. Public Health Service in detecting the introduction of this new strain of influenza into the United States. To date no known cases have occurred, but they are expected by late summer or early fall.

All cases of influenza or influenza-like illnesses should be promptly reported to the local health officer on the regular report card, a copy of which is shown below.

It should be noted that influenza cases may be reported by numbers only, rather than by individual names and addresses. Particular attention should be given to reporting cases in persons recently arriving from the Far East.

Laboratory specimens are necessary to determine the exact type of influenza virus causing an illness. The local health officer will supply the necessary instructions and containers and will assist in preparing the specimens for shipment to the laboratory. Throat washings should be obtained during the first three days of illness while the patient is still febrile. The patient should gargle three times with a sterile fluid supplied by the health department. Two specimens of whole blood should be obtained, one during the acute illness and a second, two to four weeks later. Ten cubic centimeters of clotted blood, obtained in the usual manner, will be satisfactory for each specimen. Laboratory forms to accompany these specimens will be supplied by the health department. Reports of virus isolation in the throat washings and hemagglutinin-inhibiting antibodies in the serum will be sent to the submitting physician and local health department. These will be of little direct clinical diagnostic usefulness because of the two to four week period required for completion of tests.

It is hoped that all private physicians in Florida will cooperate in this new surveillance program since the success in preventing another widespread epidemic will depend on such cooperation, and only in this way can we determine whether another prophylactic vaccine should be made available.

NOTIFIABLE DISEASE CASE REPORT FOR WEEK ENDING_____

DISEASE	PATIENT	COUNTY OR CITY	AGE	SEX	RACE
	NAME				
	ADDRESS				
	NAME				
	ADDRESS				
	NAME				
	ADDRESS				
	NAME				
	ADDRESS				

NAME OF PHYSICIAN, HOSPITAL, OR OTHER AUTHORIZED PERSON

OFFICE ADDRESS

REPORT BY NUMBERS OF CASES ONLY: MEASLES_____ WHOOPING COUGH_____ STREP. SORE THROAT INCL. SCARLET FEVER_____

INFLUENZA_____ CHICKEN POX_____ MUMPS_____ HOOKWORMS_____

Please sign and mail this card promptly even if you have no cases to report. No postage required.
PHS-2429 (9-55) Form approved.
U. S. GOVERNMENT PRINTING OFFICE. 1956 O - 387195 Budget Bureau No. 68-R580.

EFFECTIVE, DEPENDABLE THERAPY FOR VAGINITIS



Floraquin® eliminates trichomonal and mycotic infection; restores normal vaginal acidity

Leukorrhea is by far the most frequent symptom of vaginitis; trichomonads and monilia are the most common causes. Many authors have reported[2] trichomonal protozoa in the vagina of 25 per cent of obstetric and gynecologic patients. Increased use of broad spectrum antibiotics has resulted in a sharp rise in the incidence of monilial infections.

Floraquin effectively eradicates both trichomonal and monilial vaginal infections through the action of its Diodoquin® content. Floraquin also furnishes boric acid and sugar to restore the normal vaginal acidity which inhibits pathogens and favors the growth of protective Döderlein bacilli.

Pitt[1] recommends vaginal insufflation of Floraquin powder daily for three to five days, followed by acid douches and the daily insertion of Floraquin vaginal tablets throughout one or two menstrual cycles. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

1. Pitt, M. B.: Leukorrhea. Causes and Management, J. M. A. Alabama *25*:182 (Feb.) 1956.
2. Parker, R. T.; Jones, C. P., and Thomas, W. L.: Pruritus Vulvae, North Carolina M. J. *16*:570 (Dec.) 1955.

SEARLE

OTHERS ARE SAYING

FMA—Blue Shield Liaison Committee

On invitation of the Board of Directors of Florida Blue Shield and approval of the House of Delegates of the Florida Medical Association, President Francis Langley appointed seventeen physicians to form the Advisory Committee. They represent different professional and geographic areas and function under the able chairmanship of Dr. Henry J. Babers, Jr. of Gainesville.

CALIFORNIA STATE
assignments for
PHYSICIANS AND PSYCHIATRISTS

Three Salary groups: $11,400-12,600
12,000-13,200
13,200-14,400

Streamlined employment procedures—interview only
U. S. citizenship and possession of, or eligibility for Calif. license required

Write: Medical Recruitment Unit, Box A, State Personnel Board, 801 Capitol Ave., Sacramento, California



The Committee is a liaison group between Blue Shield and its participating members. Blue Shield needs us and we need it.

Unrest over too much centralization of power has been expressed recently in Picomeso only shortly after many of the same members had wanted to be shed of debate at meetings. Likewise, resentment has appeared towards the Blue Shield Board of Directors by participating members.

With Blue Shield too big for "town hall" meetings and its active members meeting only once a year with probable carryover of incompleted business, for several years, the Liaison Committee which is small enough to be flexible and large enough to be representative, will be a needed link to the chain of operation.

We cannot expect the impossible of Blue Shield. It can spend only what subscribers contribute. Although it has a substantial kitty, it is not inexhaustible. It is able to pay for necessary care, but needless or over-utilization will wreck it.

Without Blue Shield we would be in trouble. With it, we have something to gripe about. The Liaison Committee wants to learn of criticism to present to the Board for correction, if possible. It would also like to hear a compliment occasionally to pass on to headquarters.

Blue Shield was established about twelve years ago by now older members of the FMA kicking in on a loan to give it its initial operating capital. It was our baby. Newcomers too often consider it as just another insurance company. The oldtimers are very conscious of the fact that it saved us from socialized medicine. Youngsters must be aware that the social monster is not dead but sleeping and they will need this two bladed sword kept to give battle on short notice.

Mr. Schroder, its Director, has done a commendable job. Board members give their service freely. It rents space, equipment and trained labor from its sister, Blue Cross. The two distinct corporations are like twins. That which will benefit or harm one will do likewise to the other.

When coverage was only surgical, both had little trouble about people demanding hospitalization, for with surgery, there is pain. With extension to the medical field, subscribers want hospitalization galore to get their money's worth. In a hospital flowers are sent by their friends and they feel important.

WHY
SENSITIZE
in topical and ophthalmic infections

USE
'POLYSPORIN'®
brand
POLYMYXIN B—BACITRACIN OINTMENT
to insure broad-spectrum therapy with minimum allergenicity

For topical use: in ½ oz. and 1 oz. tubes.
For ophthalmic use: in ⅛ oz. tubes.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

Premium rates must remain low to serve the people for whom Blue Shield was created. By guarding utilization to necessary cases and refusing admission for rest cures will prevent rate increases.

So let us think of the patient's actual needs first, of Blue Shield second and our own physical convenience last, for a change.

Picomeso Mail Bag
Pinellas County Medical Society
March 4, 1957.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Wilfred Lansman, of Miami Beach, announce the birth of a daughter, Susan Ann, on May 1, 1957.

Marriages

Dr. Charles B. Wigderson, of Miami Beach, and Mrs. Doris Pallot, of Miami, were married May 14, 1957 in Miami.

Deaths—Members

Eaton, Joseph W., St. Petersburg	April 23,1957
Lancaster, William J., Tampa	April 26, 1957
McGugan, Arthur, Denver, Colo.	May 28, 1957
Mason, John F., Bradenton	May 22, 1957
Schirmer, Adelbert F., Orlando	April 5, 1957

Deaths—Other Doctors

Griffin, James Burnie, St. Augustine	April 24, 1957

STATE NEWS ITEMS

The Eighth Scientific Assembly of the Florida Academy of General Practice will be held in the Soreno Hotel at St. Petersburg, October 31 to November 2. Dr. Elmer B. Campbell Sr., of St. Petersburg, Chairman of the Program Committee of the Academy, is in general charge of the program. Assisting him are Drs. Harry R. Cushman and Frank L. Price, both of St. Petersburg.

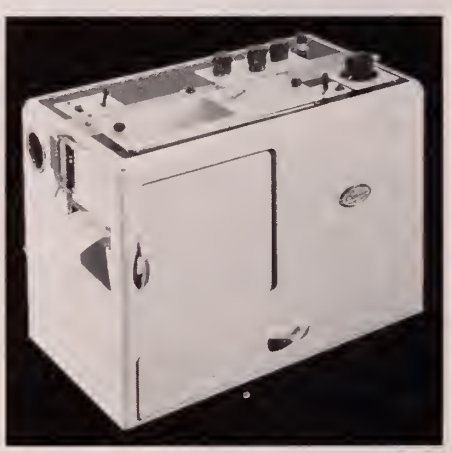
Symposiums on antibiotics, arthritis, practical biochemistry and stress have been planned with such prominent speakers as Dr. Hans Selye, Professor of Medicine, University of Montreal Faculty of Medicine, Quebec, and Dr. Malcom E. Phelps, President of the American Academy of General Practice.

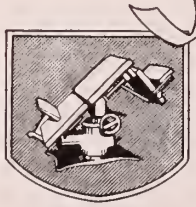
Dr. M. Jay Flipse of Miami has been elected Second Vice President of the American College of Chest Physicians. Dr. Arnold S. Anderson of St. Petersburg has been chosen a member of the Board of Regents, and Dr. Alexander Libow of Miami Beach has been selected Governor of the College for Florida.

The BURDICK ELECTROCARDIOGRAPH

A THOROUGHLY RELIABLE INSTRUMENT
PRECISION RECORDING

— Ask for Demonstration —





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AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A.

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T. B. SLADE, JR. J. BEATTY WILLIAMS

optimal dosages for ATARAX,
based on thousands of case histories:

25 *mg. (t.i.d.)*

for these **25** *adult indications:*

TENSION · SENILE ANXIETY · MENOPAUSAL SYNDROME · ANXIETY · PREMENSTRUAL TENSION
PHOBIA · HYPOCHONDRIASIS · TICS · FUNCTIONAL G. I. DISORDERS · PRE-OPERATIVE ANXIETY
HYSTERIA · PRENATAL ANXIETY · AND ADJUNCTIVELY IN CEREBRAL ARTERIOSCLEROSIS
PEPTIC ULCER · HYPERTENSION · COLITIS · NEUROSES · DYSPNEA · INSOMNIA
PRURITIS · ASTHMA · ALCOHOLISM · DERMATITIS · PARKINSONISM · PSORIASIS

perhaps the safest ataraxic known

PEACE OF MIND ATARAX® *Tablets-Syrup*
(BRAND OF HYDROXYZINE)

10 *mg. (t.i.d.)*

for these **10** *pediatric indications*

ANXIETY · TICS · HOSTILITY · NIGHTMARES · HYPEREMOTIVITY · RESTLESSNESS
TEMPER TANTRUMS · HOSPITAL FEAR · AND ADJUNCTIVELY IN ASTHMA · ENURESIS

Consider these 3 ATARAX *advantages:*

- 9 of every 10 patients get release from tension, without mental fogging
- extremely safe—no major toxicity is reported
- flexible medication, with tablet and syrup form

Supplied:

In tiny 10 mg. (orange) and 25 mg. (green) tablets, bottles of 100.

ATARAX Syrup, 10 mg. per tsp., in pint bottles. Prescription only.

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WHO SUFFERS
IN THE
MENOPAUSE
DESERVES
"PREMARIN"®

widely used
natural, oral
estrogen

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5646

Dr. Arthur J. Butt of Pensacola is touring Europe as guest lecturer and guest researcher at several European universities and medical institutions. He will be guest speaker at Queens University in Belfast, Ireland, while on the continent.

Dr. J. Basil Hall of Tavares discussed "Rabies Epidemic and Four Years Later" at the recent meeting of the Southern Public Health Association held at Asheville, N. C.

Among members of the Florida Medical Association who appeared on the program of the Scientific Assembly of the recent American Medical Association meeting in New York were the following: Dr. Louis F. Hubener of Gainesville, joint author of the paper "Experimental Production of Acne by Progesterone;" Drs. Gus G. Casten of Miami and Robert J. Boucek, North Miami Beach, "The Use of Relaxin in the Treatment of Scleroderma;" Dr. John R. Neefe of St. Petersburg, "Management of Hepatitis;" Dr. Stephen P. Gyland Sr. of Tampa, "Functional Hyperinsulinism in General Practice;" Dr. James H. Ferguson of Miami, "Rupture of the Marginal Sinus;" Drs. Ralph E. Kirsch, Philip Samet, Victor H. Kugel and Stanley H. Axelrod of Miami Beach, "Electrocardiographic Changes During Ocular Surgery and Their Prevention by Retrobulbar Injection."

Dr. Neefe also served as moderator for a panel discussion on hepatitis.

Dr. M. Jay Flipse of Miami served as Vice Chairman of the Section on Diseases of the Chest. Dr. Clarence Bernstein of Orlando filled the position of Secretary of the Session on Allergy, and Dr. Milton M. Coplan of Miami served as Representative to Scientific Exhibit, Section on Urology.

Dr. George W. Karelas of Newberry has been appointed chairman of the Committee on Rural Health of the American Academy of General Practice. He also serves as chairman of the Committee on Rural Health of the Florida Academy of General Practice.

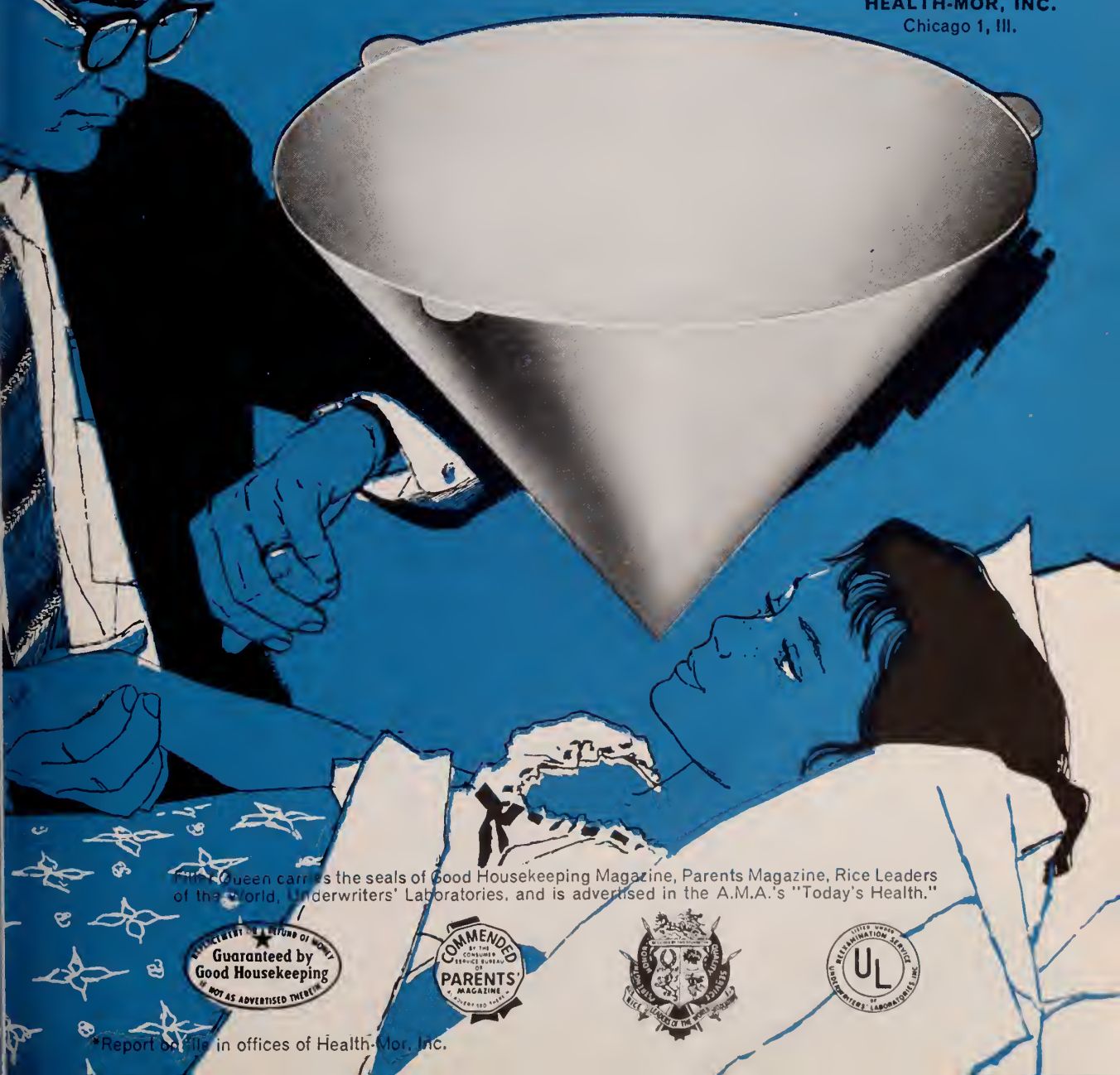
Dr. Turner Z. Cason of Jacksonville has been reelected president of the Northeast Florida Heart Association. Among the directors chosen from the Jacksonville area were Drs. John D. Ferrara, J. Webster Merritt, Harry W. Reinstine and Sidney Storch. (*Continued on page 183*)

Alleviate Dust Allergy *in the home*

Thanks to Filter Queen's remarkable air purifying action, patients with dust allergies enjoy fast relief right in their own homes. Dust allergic housewives report complete freedom from dust irritation, even during heavy household work. Filter Queen is an entirely different kind of appliance that utilizes an unique, highly effective Sanitary Filter Cone to obtain protection against dust and dirt in the home. It will actually collect matter *as fine as smoke* and return clean filtered air into the room! Unbiased, scientific proof of Filter Queen's air purifying efficiency is shown by a recent report from the Biological Sciences department of an eastern university which states: *"The Filter Queen cellulose Filter Cone removes practically all dust and atmospheric pollen."** A free Filter Queen demonstration will gladly be arranged at your convenience. Phone your local Filter Queen Distributor or write Health-Mor, Inc., 203 N. Wabash Ave., Chicago 1, Ill.



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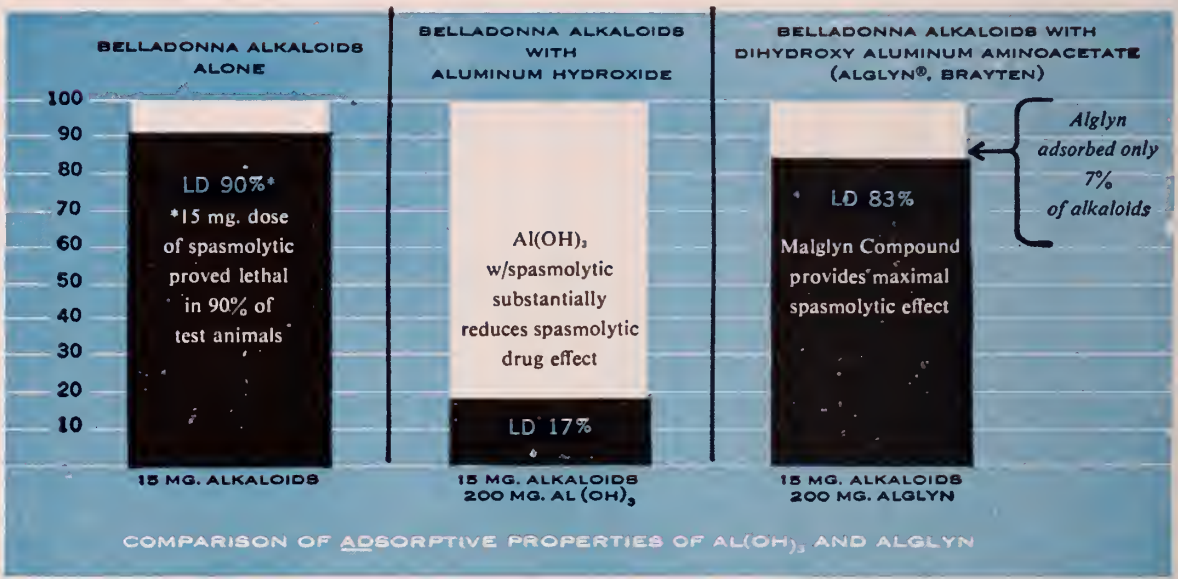
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belladonna alkaloids (as sulfates)	0.162 MG.
phenobarbital	16.2 MG.

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Specialities for the Medical Profession only

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(Continued from page 178)

Dr. James N. Patterson of Tampa has returned from Chicago where he attended a meeting of the Board of Directors of the American Association of Blood Banks.

Dr. I. Leo Fishbein of Miami Beach is in Europe where he is visiting psychiatric hospitals and clinics. In September, Dr. Fishbein will be in Zurich, Switzerland, for the Second International Congress of Psychiatry.

Dr. Jacob A. Glassman of Miami Beach, Assistant Clinical Professor of Surgery at the University of Miami School of Medicine, was one of the principal speakers at the Annual Postgraduate Seminar presented by the International College of Surgeons in mid-July at the Cook County Postgraduate School of Medicine in Chicago.

Dr. Glassman's subjects were "Umbilical and Post-Operative Hernias" and "The Present Status of Thyroid Surgery."

Dr. Samuel M. Day of Jacksonville, Secretary-Treasurer of the Florida Medical Association, addressed a joint meeting of the Lee-Charlotte-Hendry and Collier County Medical Societies on June 17. The following day, Dr. Day was principal speaker at a combined meeting of the Manatee and Sarasota County Medical Societies. His topic was "Problems of Blue Shield."

Mr. Ben C. Willis of Tallahassee, who has been an attorney for the Florida Medical Association assisting the Committee on Legislation and Public Policy for the past ten years, has been appointed judge of the Second Judicial Circuit by Governor LeRoy Collins.

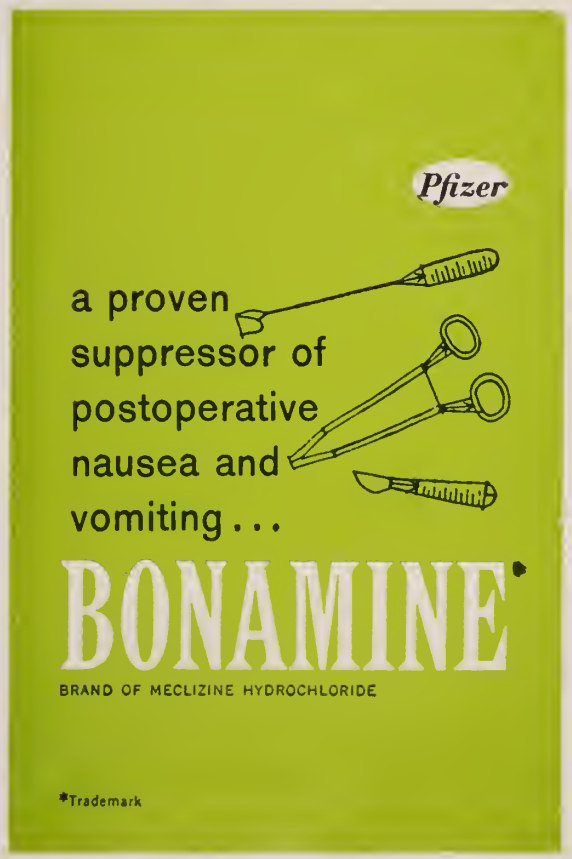
Dr. Joseph M. Bistowish of Tallahassee has been elected president of the Southern Branch of the American Public Health Association.

Dr. Alfred P. Seminario of St. Petersburg has returned from an extensive tour of various countries in South America. He lectured by invitation at the British Hospital and Medical School at Buenos Aires, visited the Orthopedic Society at Lima, Peru, of which he has been a corresponding member for several years, and addressed a group at Caracas, Venezuela.

Dr. Bruce W. Alspach of Miami has been elected president of the Greater Miami Society of Psychiatry and Neurology. Dr. Bernard Goodman of Miami Beach is vice president and Dr. James J. Goodman of Miami, secretary-treasurer.

Dr. Jim S. Jewett of Coral Gables has been installed as president of the Heart Association of Greater Miami. Other officers are Dr. Louis Lemberg of Miami, president-elect, and Dr. Francis N. Cooke of Miami, vice president.

The training course "Management of Mass Casualties" is being presented at the Walter Reed Army Medical Center, Washington, D. C., September 9-14 and December 2-7, 1957 and May 12-17, 1958. The course is also being offered at the Army Medical Service School, Fort Sam Houston, Texas, Nov. 18-22, 1957. There is a quota for each course, and physicians interested in attending should send their name, priority of location and date three months in advance to the State Civil Defense Office or to the Federal Civil Defense Administration, Region III, Thomasville, Ga.



Dr. John T. Karaphillis of Clearwater has been visiting various clinics and hospitals in Greece and England.

Dr. George D. Conger of Miami has been elected grand chancellor of the Domain of Florida of the Knights of Pythias.

Dr. Sullivan G. Bedell of Jacksonville and Dr. John D. Milton of Miami have been appointed by Governor LeRoy Collins to the State Board of Health. Dr. Bedell succeeds Dr. Carl C. Mendoza of Jacksonville, and Dr. Milton succeeds Dr. Herbert L. Bryans of Pensacola.

Dr. Turner Z. Cason of Jacksonville has been presented a plaque by the College of Medicine of the University of Florida in recognition of 25 years service as Chairman of the Medical Postgraduate Course Committee of the Florida Medical Association which annually sponsors the Graduate Short Course for physicians.

Dr. Thomas D. Cook of New Smyrna Beach has been elected chairman of the American Red Cross Chapter of that city.

Dr. J. Rocher Chappell of Orlando was principal speaker at a recent meeting of the Ocala Rotary Club. Dr. Chappell appeared on the program as medical officer of the State Civil Defense Program.

Dr. William D. Rogers of Chattahoochee has been selected to direct Florida's mental hospitals at Chattahoochee, Arcadia, Hollywood and Macclenny.

Dr. Richard G. Connar of Tampa was one of the principal speakers at the recent national convention of Kappa Delta Phi held in Tampa.

Dr. Seymour W. Rubin of Miami Beach has returned from Pittsburgh where he attended the meeting of the American Urological Association and participated in the scientific exhibit on "Substitute Urinary Bladder."

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References: (1) Holt, J. O. S., Jr.: Dallas M. J. 42:497, 1956. (2) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. 1:155, 1956. (3) Natenshon, A. L.: Am. Pract. & Digest Treat. 7:1456, 1956.

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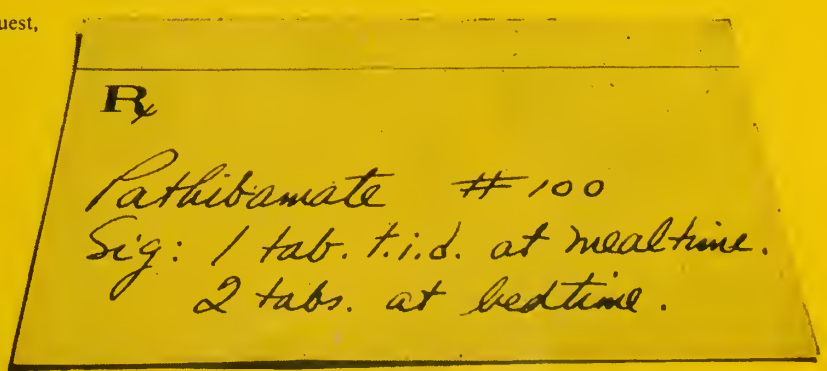
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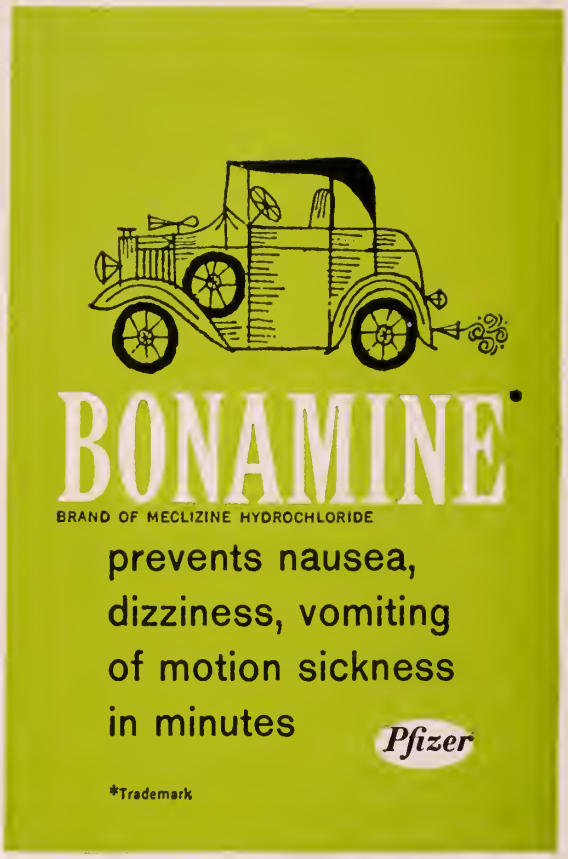
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rle Laboratories. 6. Texter, E. C., Jr.: Personal
munication to Lederle Laboratories. 7. Bauer, H. G.
McGavack, T. H.: Personal Communication
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WANT TO BUY: Used binocular microscope suitable for medical student. Write 69-227, P. O. Box 2411, Jacksonville, Fla.

LOCUM TENENS: July 1, 1957 to January 1, 1958. General Practitioner to associate with same. Suburban Jacksonville. To future association as agreed. Write 69-229, P.O. Box 2411, Jacksonville, Fla.

WANTED: Specialist in Obstetrics and Gynecology with Florida license to associate with group in Dade-Broward area. Board man preferred. Write age, training, chronology of medical experience, references. Write 69-230, P. O. Box 2411, Jacksonville, Fla.

WANTED: Pediatrician or General Practitioner with special training in pediatrics to associate with group in Dade-Broward area. Florida license necessary. Write age, training, chronology of medical experience, references. Write 69-231, P. O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner or Specialty-General Practitioner combination. Can put you on percentage to start, with $1000 per month minimum guarantee. Write 69-235, P. O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner as an associate for an established practice, suburb of Jacksonville. Clinic type building, ample treatment rooms, laboratory and other facilities. Interest in OB helpful. Write 69-236, P. O. Box 2411, Jacksonville, Fla.

OBSTETRICIAN-GYNECOLOGIST: Board or board eligible, to associate with mixed group of three in a well established practice in town of 50,000 in central Florida. Write 69-233, P. O. Box 2411, Jacksonville, Fla.

TO SETTLE AN ESTATE: Complete doctor's office. Old, established location. Clientele can be reactivated immediately. Terms. Income unlimited. Write to Mrs. F. J. Farley, 420 North 7th St., Dade City, Florida.

RADIOLOGIST: Desires association with radiologist, group or hospital. Fifty years. Board certified, isotope license. Expensive experience in diagnosis, therapy, radium and isotopes. Several publications. Florida license. Write 69-234, P. O. Box 2411, Jacksonville, Fla.

WANTED: Laboratory and X-Ray technician. Better than average salary. 44 hour week. For information please contact Dr. Edward Gonzalez, 300 Simonton St., Key West, Fla. Phone CY 6-2714.

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PRACTICE FOR SALE: Active general practice, west Florida town near large Airbase. New Hospital. Town needs physician with surgical training. Write 69-237, P.O. Box 2411, Jacksonville, Fla.

INTERNIST: desires partnership with another internist; hospital staff also considered. Florida license, married, age 31. Board certified. Write 69-239, P.O. Box 2411, Jacksonville, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Berquist, Francis L., Lakeland
Butscher, William C. Jr., Ocala
Campbell, Lindsey, D., Chattahoochee
Chambers, William N., Jacksonville
Conn, James K., Tallahassee
Coppola, Vincent Jr., Fort Lauderdale
Cronick, Charles H., Chattahoochee
Duke, Joseph E., Bradenton
Fusco, Ralph J., Miami
Gist, William T., Canal Point
Harrison, Ben L., Miami
Hendrix, Claude A. Jr., Fort Lauderdale
Hopkins, Wililam B. Jr., Tampa
Ireland, Treadwell L., Lake City
Isham, Robert L., Miami
Jonsson, Ulfar, Miami
King, William B., Tampa
Kohen, Roland J., Miami
Martin, Richard A., Fort Lauderdale
Neale, Richard C., Tampa
Ostling, Burton C., Avon Park
Pavlin, Otto B., Bradenton Beach
Pedigo, Howard K., Bradenton
Rawls, Thompson T., Pompano Beach
Regan, Thomas F., Hollywood
Simon, Howard M. Jr., Hialeah
Vargas, Alvaro, Miami
Watt, Francis H., Tallahassee
Weber, Robert G., Fort Lauderdale

John D. Rockefeller once said, "The ability to deal with people is as purchasable a commodity as sugar or coffee and I will pay more for that ability than for any other under the sun."

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The Bulletin, Dade County Medical Association

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Ferrous Sulfate	50 mg.	Pyridoxine Hcl.	0.3 mg.
Rutin	10 mg.	Niacinamide	20 mg.
Ascorbic Acid	30 mg.	Manganese	1 mg.
B-12	1 mcg.	Magnesium	5 mg.
Molybdenum	0.5 mg.	Iodine	0.15 mg.
Cobalt	0.1 mg.	Potassium	2 mg.
Copper	0.2 mg.	Zinc	1 mg.
Vitamin A	5,000 I.U.	Choline Bitartrate	40 mg.
Vitamin D	400 I.U.	Methionine	20 mg.
Vitamin E	1 I.U.	Inositol	20 mg.
Cal. Pantothenate	3 mg.		

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*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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MRS. JAMES M. WEAVER, 4th Vice Pres...*Fart Lauderdale*
MRS. WENDELL J. NEWCOMB, Recording Sec'y....*Pensacola*
MRS. WILLARD L. FITZGERALD, Treasurer.....*Miami*

Report of Annual Meeting of Woman's Auxiliary to A. M. A.

Twenty-one delegates and alternates represented the Woman's Auxiliary to the Florida Medical Association at the Thirty-fourth Annual Meeting of the Woman's Auxiliary to the American Medical Association at the Roosevelt Hotel in New York City, June 3-7, 1957.

All were pleased when Florida was recognized in several ways. First came the report of the Past President, Mrs. Scottie J. Wilson, which was read by Mrs. Perry D. Melvin, President for 1957-58. It was gratifying to hear the Florida report and to realize that the past year had been an outstanding one, comparing quite favorably with the reports of the other states. Florida was again spotlighted when the *Today's Health* Contest awards were given. Escambia County Auxiliary received the second prize of $25 for Group III Auxiliaries (those with a membership of 76 to 100); and Broward County Auxiliary received the third prize of $15 for Group IV Auxiliaries (those with a membership of 101 or over). It was also told that 15 counties in Florida exceeded 100 per cent of their contest subscription quota. Mrs. Wilson accepted these awards for the Florida Auxiliary, and was also present at the *Today's Health* Breakfast, honoring the states which had exceeded their subscription quota.

To the Florida group, the highlight of the convention was the election of Mrs. Richard F. Stover, Miami, as Third Vice-president of the Woman's Auxiliary to the American Medical Association. Mrs. Stover has ably served as Constitutional Secretary of the national organization during the 1956-57 year.

Socially, the convention was a most pleasant occasion also, with a tea and fashion show, two luncheons and a banquet adding to the pleasure of the meeting. Many also enjoyed the gracious hospitality in the Florida Room at the Waldorf Hotel.

— 41 years —

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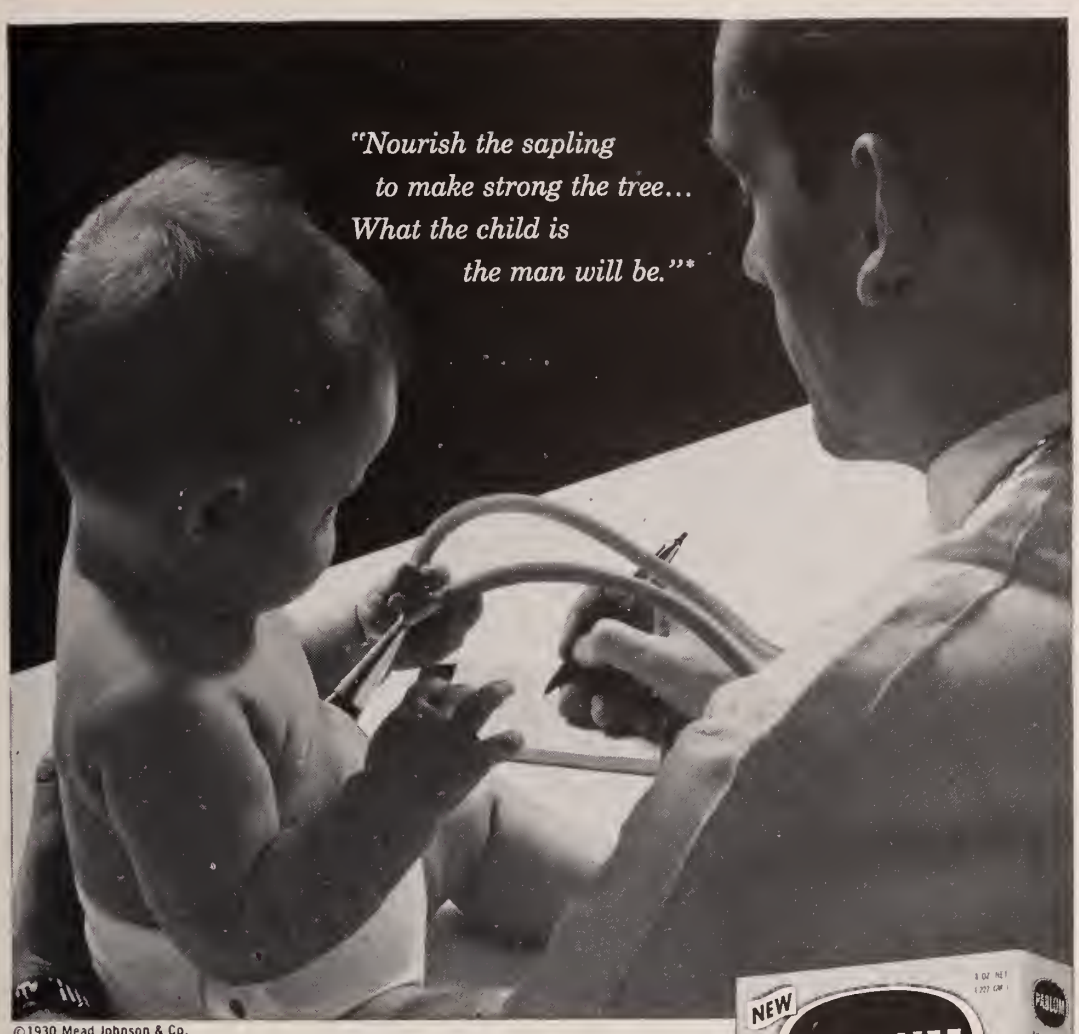
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BOOKS RECEIVED

Expectant Motherhood. By Nicholson J. Eastman, M.D. Pp. 198. Price, $1.75. Boston, Little, Brown & Company, 1957.

This new revised third edition of this little book appears 10 years after the second edition. It incorporates the principal advances made in maternity care over the past decade to the end that it may continue to serve as a thoroughly modern guidebook for expectant mothers. Largely distributed by physicians, this handy volume has gained an extraordinary recognition over the years. It is likely that more than five million pregnant women have found it a constant and useful aid during pregnancy. The new edition does not attempt to make radical changes in a book which over the last 16 years has proved its value, but new information has been added on such matters as anesthesia, diet for mothers, equipment for both mother and baby. Basically unchanged, however, the text still offers a common sense approach to pregnancy, and this fact has made it the book of choice of thousands of obstetricians and general practitioners.

The author of this complete, calm, understanding, authoritative and reassuring guidebook through pregnancy is Professor of Obstetrics at Johns Hopkins University and Obstetrician in Chief to the Johns Hopkins Hospital. He has made his handbook really a supplement to a doctor's advice, for he realizes how many questions may be left unasked, how many instructions may be only partly understood, how many small uncertainties occur from day to day.

Organized Home Medical Care in New York City. *A Study of Nineteen Programs.* By the Hospital Council of Greater New York. Pp. 538. Price, $8.00. Published for The Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1956.

Home medical care in its modern form is a recent development that led to this study of organized home medical care programs existing in New York City on a more or less experimental basis. That organized home medical care for the indigent and medically indigent is not now provided widely over the country is added justification for the publication of this report. The objectives of the study were: to describe and evaluate existing facilities for provision of organized home care services in New York City; to determine, by direct interviewing, how patients and their families have reacted to home medical care; to establish standards for the operation of home care programs and for the types of services that should be provided; to suggest broad criteria for suitability of patients for home care; to discuss methods of administering home care programs and to formulate criteria for determining the qualifications of a hospital to operate such a program; to develop methods of integrating home care programs with the total pattern of services furnished by hospitals; and to formulate a long range plan for distribution of home care services throughout New York in order to assure optimal coverage for all indigent and medically indigent persons.

The report covers 19 home medical care programs, including 16 operated by municipal hospitals, and directs attention to the kinds of patients served, their diagnoses and lengths of stay under home care, the services rendered, and the comments of patients and their families. In addition, it compares different types of programs, and considers in detail the problems of personnel and administration, the relation of home care to hospital care, and the costs involved. This is the most extensive study of organized home medical care programs thus far published, and the suggested standards for establishing and operating new programs are more detailed and concrete than any previously published.

Handbook of Pediatric Medical Emergencies. By Adolph G. DeSanctis, M.D., with the collaboration of Charles Varga, M.D., and Ten Contributors. Ed. 2. Pp. 389. Illus. 73. Price, $6.25. St. Louis, The C. V. Mosby Company, 1956.

The material in the first edition of this Handbook was prepared over a period of years to serve as a guide for members of the resident staff and for physicians enrolled in the courses offered by the Pediatric Department of the Post-Graduate Medical School of New York University-Bellevue Medical Center. A small handbook was printed privately for general distribution. It was so well received in the United States and many foreign countries that after the fourth printing was exhausted, a second edition was undertaken.

Much of the text of this second edition has been completely rewritten and new illustrations and tables have been added. The chapters on Metabolic Emergencies, Accident and Poison Prevention, Genitourinary Emergencies, and Respiratory Paralysis in Poliomyelitis are new. Additions have been made to the list of household poisons. Although references are made to methods and procedures used in other medical centers and hospitals, the text represents the methods used in University Hospital, New York University-Bellevue Medical Center.

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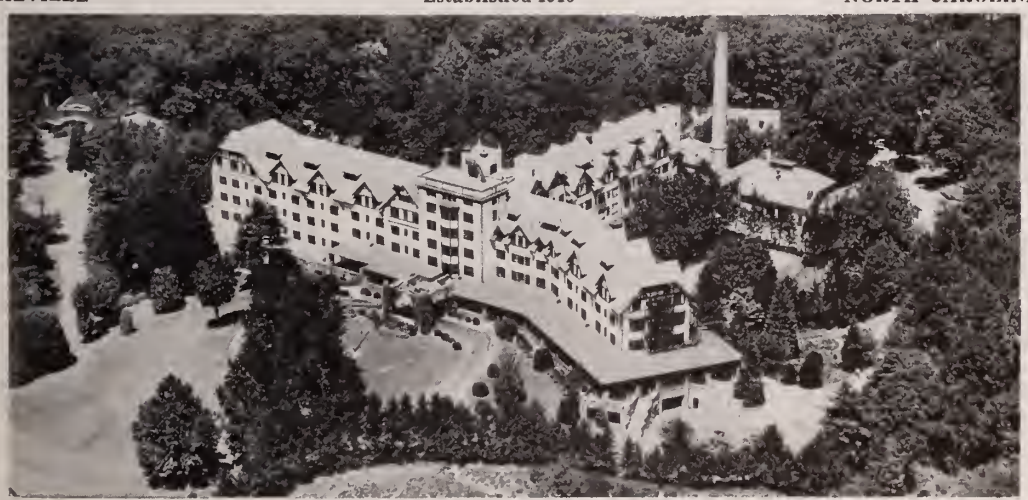
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Bay	John J. Benton, Panama City	Lloyd B. Harrison Jr., Panama City	1st Tues.	29
Brevard	Myron L. Habegger, Rockledge	Louis C. Jensen Jr., Rockledge	2nd Tues.	51
Broward	Walter J. Glenn Jr., Fort Lauderdale	Garland M. Johnson, Fort Lauderdale	4th Tues.	170
Collier	James A. Craig, Naples	Ethel H. Trygstad, Naples	3rd Wed.	9
Columbia	Thomas H. Bates, Lake City	Laurie J. Arnold Jr., Lake City	1st Mon.	11
Dade	Walter W. Sackett Jr., Miami	Vincent P. Corso, Miami	1st Tues.	816
DeSoto-Hardee-Highlands-Glades	Godfrey L. Beaumont, Sebring	Theodore W. Weeks Jr., Sebring	1st Tues.	28
Duval	Leo M. Wachtel, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	334
Escambia	Paul F. Baranco, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	112
Franklin-Gulf	Photis J. Nichols, Apalachicola	William F. Wager, Port St. Joe	Last Wed.	6
Hillsborough	Madison R. Pope, Plant City	James A. Winslow Jr., Tampa	1st Tues.	220
Indian River	Walter W. McCorkle, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	10
Jackson-Calhoun	William W. Richardson, Graceville	Francis M. Watson, Marianna	Quarterly	17
Lake	Fred A. Vincenti, Mount Dora	J. Basil Hall, Tavares	1st Wed.	31
Lee-Charlotte-Hendry	James L. Bradley, Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	George S. Palmer, Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	76
Madison	Julian M. DuRant, Madison	A. Franklin Harrison, Madison		8
Manatee	Joseph A. Gibson, Bradenton	Warren G. Darty, Palmetto	2nd Tues.	31
Marion	John D. Lindner, Ocala	Robert L. Gibson, Ocala	3rd Tues.	36
Monroe	Robert W. Reid, Key West	Joseph J. Scarlet, Key West	1st Thurs.	13
Nassau	Benj. F. Dickens, Fernandina Beach	David D. Bennett Jr., Callahan	1st Thurs.	9
Orange	Frank J. Pyle, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	216
Palm Beach	Edward W. Wood, Lake Worth	Robert Y. Wheelihan, Riviera Beach	4th Mon.	158
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	19
Pinellas	Percy H. Guinand, Clearwater	Whitman C. McConnell, St. Petersburg	1st Mon.	261
Polk	John P. Tomlinson Jr., Lake Wales	Charles Larsen Jr., Lakeland	2nd Wed.	115
Putnam	Alfred P. Peretti, Palatka	Norman B. Edgerton, Palatka	2nd Tues.	11
St. Johns	Milton Segal, St. Augustine	William J. Gibson, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	John M. Gunsolus, Stuart	Adrian M. Sample, Fort Pierce	3rd Thurs.	28
Sarasota	Samuel E. Kaplan, Venice	James E. Kicklighter, Sarasota	2nd Tues.	69
Seminole	Gordon D. Stanley, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee-Hamilton-Lafayette	Hiram B. Curry, Jasper	William P. Blackmon, Jasper	1st. Sat.	11
Taylor	Charles R. Wiley, Perry	Ralph J. Greene, Perry	Last Fri.	5
Volusia	Arthur Schwartz, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	92
Walton-Okaloosa-Santa Rosa	Ralph B. Spires, DeFuniak Springs	Howard A. Parker, Valparaiso	3rd Tues.	26
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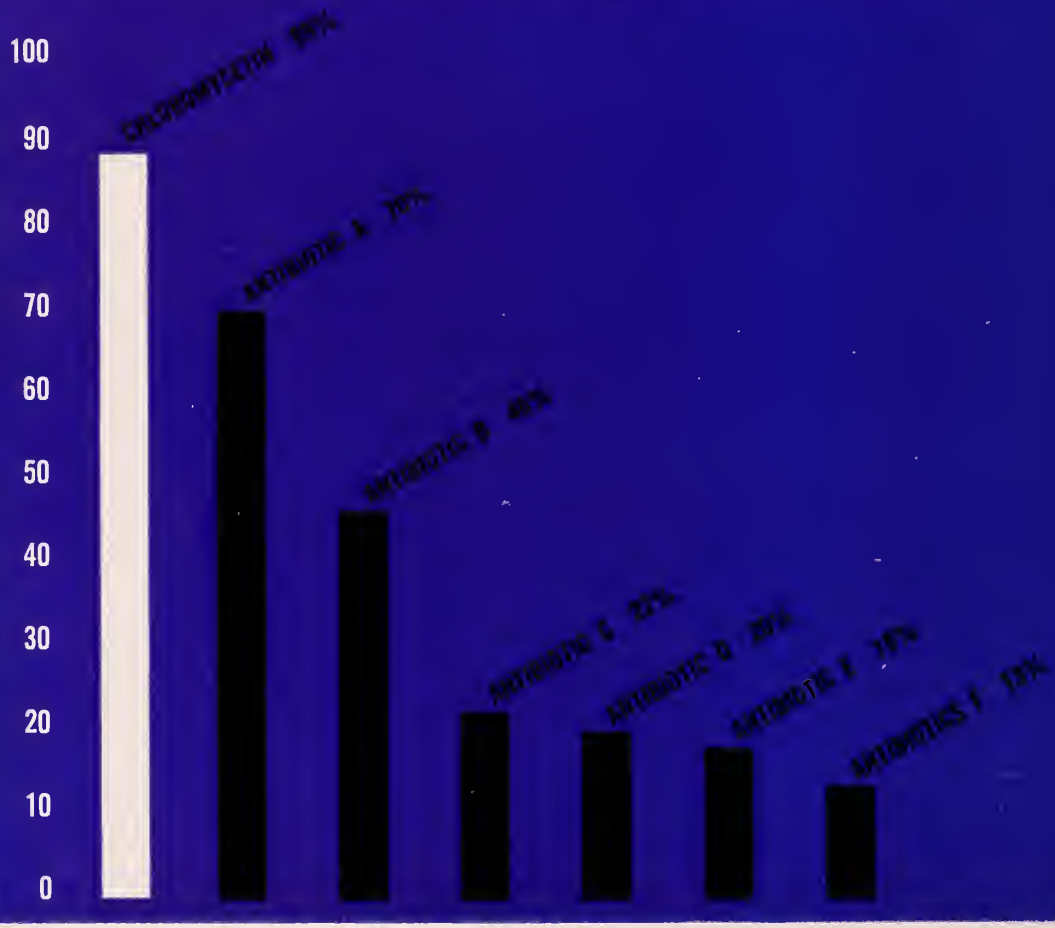
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*This graph is adapted from Kempe, C. H.: *California Med.* 84:242, 1956. The single bar designated as "Antibiotics F" represents three widely used, chemically related agents grouped together by the investigator. Strains isolated January-June, 1954.

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A REPORT ON A PROMISING CONCEPT IN ANTIMICROBIAL THERAPY: CONCURRENT ADMINISTRATION OF CHLOROMYCETIN AND GAMMA GLOBULIN

In treatment for infection, the physician is confronted with complex interactions between pathogen, antimicrobial agent and host. The pathogen represents the unselected factor, the therapeutic agent the component over which the physician exercises maximum control. But even with optimal antibiotic therapy, the eventual elimination of the infective agent and the resolution of pathologic changes depend upon efficient host response.[1,2]

Passive transfer of antibodies through gamma globulin provides a broad antibacterial spectrum because of origin in adults exposed to a variety of microorganisms. Employed as a protective element against some of the more common contagious diseases, gamma globulin permits more competent participation by the host in the fight against established infection.

Rationale for immuno-antibiotic therapy lies in simultaneous direct attack on the pathogen and re-enforced host resistance, which implies usefulness in treatment for acute fulminating, highly refractory, or prolonged infections.

EXPERIMENTAL STUDIES ENCOURAGING

In carefully controlled studies in mice, Fisher and his colleagues in Parke-Davis Research Laboratories, using pooled human gamma globulin and Chloromycetin (chloramphenicol, Parke-Davis) concurrently, demonstrated a high degree of therapeutic effectiveness in infected animals.[3] Five types of infection induced with species of Staphylococcus aureus, Streptococcus pyogenes, Proteus vulgaris and Pseudomonas aeruginosa responded to joint therapy with gamma globulin and Chloromycetin, each agent having shown at deliberately low doses in previous work little or no activity in these mouse infections when used separately. Fisher's experiences with hemolytic streptococci have been confirmed.[4]

Tests now in progress with pneumococci, salmonellae and additional strains of pseudomonas and proteus indicate that marked increases in survival rates may be anticipated in any infection where chloramphenicol has previously demonstrated therapeutic activity.[3] These observations suggest that immuno-antibiotic therapy can effect cures in a variety of refractory microbial diseases.

PROMISING IN EARLY CLINICAL TRIAL

Observations analogous to those of Fisher have been reported from the clinic.[5-7] More recently, the clinical use of gamma globulin in conjunction with antibiotics was undertaken by Waisbren[8] on the basis of Fisher's experimental work. His series of 46 patients with systemic and localized infections due to various strains of staphylococcus, pseudomonas, salmonella, proteus and to the pneumococcus had failed to respond to maximum effort with conventional therapeutic measures. Marked clinical improvement in six of these acutely ill patients shows clearly "...that in certain instances the addition of gamma globulin to antibiotic therapy may give a clinical result that could not have been obtained with the antibiotics used alone. In each of these cases, a long and extensive control period in which antibiotics were being vigorously administered had failed to produce a response but when gamma globulin was given with approximately the same dosages of antibiotic, rather marked improvements occurred."[8]

While the precise mechanism underlying the salutary effect of gamma globulin remains to be clarified, the existence of quantitative hypogammaglobulinemia was ruled out in patients in this series.[8]

A RATIONALE FOR IMMUNO-ANTIBIOTIC THERAPY

Although the relationship of susceptibility to infection and status of the host is well recognized, host resistance is an aspect of infectious disease still not understood in an era of extensive and of massive antibiotic therapy. Most antibiotics, in concentrations tolerated by living tissues, have bacteriostatic rather than bactericidal effect. In the clinic, bacteriostatic doses are most frequently given and host defense mechanisms are responsible for the eventually satisfactory clinical result.[4]

The problem of therapeutic failures despite vigorous courses of antibiotic therapy may be due to some disturbance in the immune process.[9] In addition, disproportionately high mortality rates in the extremes of life lend support to the impression of inadequate defense mechanisms, since these are underdeveloped and immature in the very young and may be impaired or depressed in the aged.[4]

Any discussion of immuno-antibiotic treatment must at present remain largely conjectural. From preliminary evidence, however, this approach to therapy appears worthy of consideration, especially in patients in whom adequate antibiotic therapy for active infectious processes has been disappointing. While the concept of enlisting the aid of the host in combating pathogenic microbes, thereby affording the physician control of two of the three principal interacting factors, is not new, enhancement of host resistance through use of gamma globulin in treatment for microbial disease is indeed a promising one.

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The Journal of the Florida Medical Association

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VOLUME XLIV, No. 3 • *September, 1957*

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This Journal is not responsible for the opinions and statements of its contributors.

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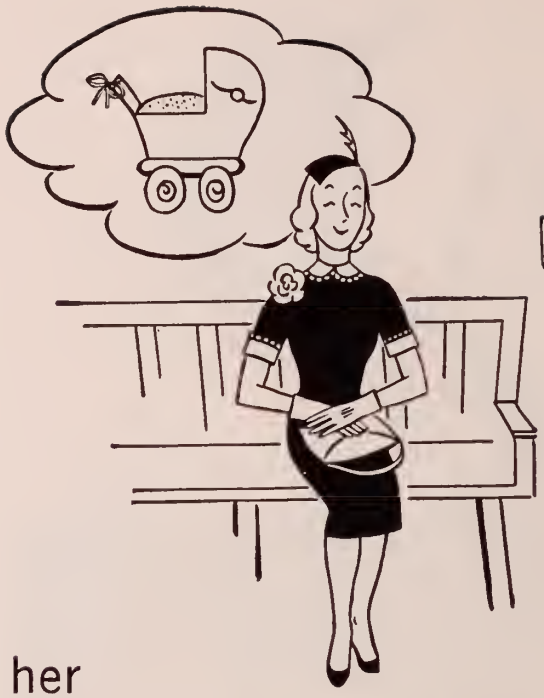
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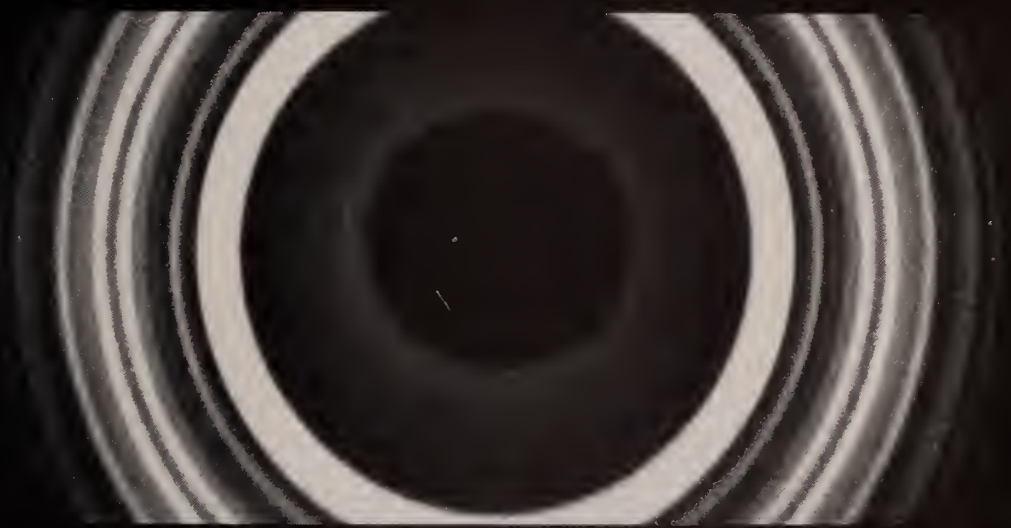
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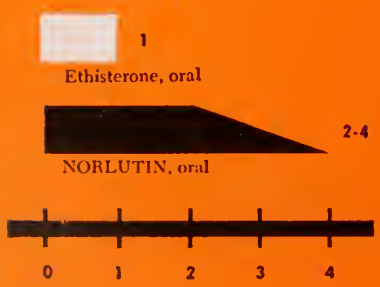
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REFERENCES: (1) Hertz, R.; Tullner, W., & Raffelt, E.: *Endocrinology* 54:228, 1954. (2) Greenblatt, R. B.: *J. Clin. Endocrinol.* 16:869, 1956. (3) Hertz, R.; Waite, J. H., & Thomas, L. B.: *Proc. Soc. Exper. Biol. & Med.* 91:418, 1956. (4) Tyler, E. T.: *J. Clin. Endocrinol.* 15:881, 1955. (5) Greenblatt, R. B., & Clark, S. L.: M. Clin. North America, Philadelphia, W. B. Saunders Co. (Mar.) 1957, p. 587.

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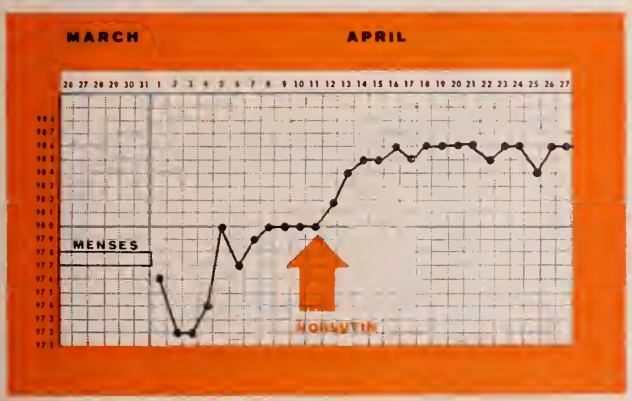
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1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954



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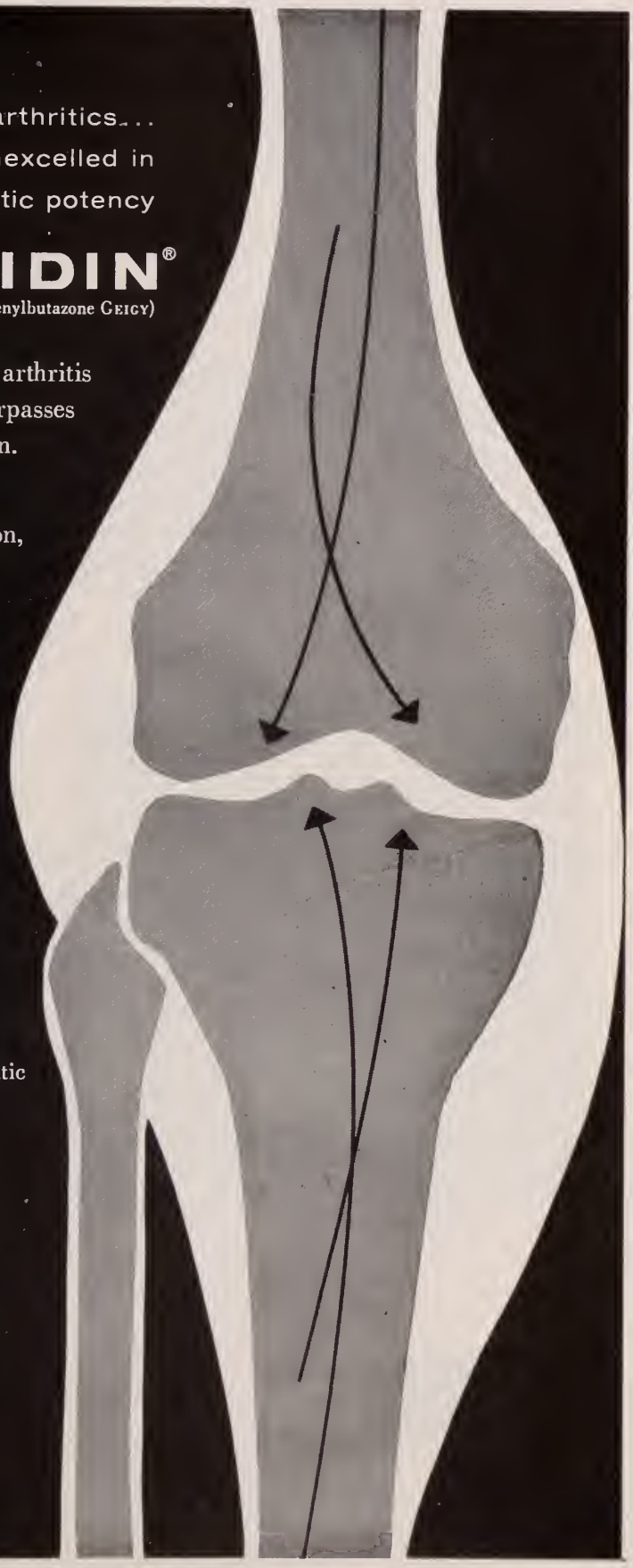
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1. Bodkin, L. G., and Ferguson, E. A., Jr.: Am. J. Digest. Dis. 18:59 (Feb.) 1951. 2. Arthur, R. P., and Shelley, W. B.: J. Invest. Derm. 25:341 (Nov.) 1955. 3. McGivney, J.: Texas J. Med. 47.770 (Nov.) 1951.

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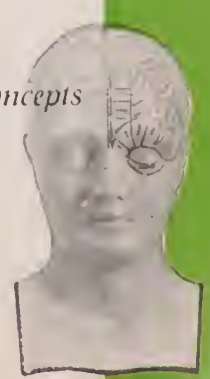
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The Journal of The Florida Medical Association
PUBLISHED MONTHLY

Volume XLIV | Jacksonville, Florida, September, 1957 | No. 3

Toxoplasmosis, Congenital and Acquired

Ocular Manifestations

Sherman B. Forbes, M. D.
TAMPA

Human toxoplasmosis is a disease of increasing importance which offers a challenge in diverse branches of medicine. The numerous recent publications on the actual and suspected role of Toxoplasma in human disease have aroused widespread interest in the clinical manifestations and the diagnosis of this infection, both in its congenital and acquired forms. Toxoplasmosis now commands the special interest of the pediatrician, the obstetrician, the general practitioner and other specialists as well as the ophthalmologist. In ophthalmology, recent investigations point to this disease as a highly important factor both in infantile and in adult uveal inflammation. Since it poses problems likewise for other specialists, the purpose of this paper is to present a general clinical approach to the subject, with discussion of the systemic as well as the ocular manifestations of the disease, stressing in particular the problem of prevention of the congenital form with its dire consequences. Illustrative cases recently reported[1] are reviewed and new cases reported.

Toxoplasma gondii, a crescentic or arc-shaped organism with one end attenuated and the other more rounded, was first described in 1909 and its pathogenicity demonstrated in mice.[2] American consciousness of this protozoan parasite, however, stems only from 1939 when its role in human disease was first determined by its recognition in spontaneous human encephalitis in an infant.[3] Worldwide in distribution, this cosmopolitan organism is naturally transmitted among many animals and certain birds, and seemingly also to hundreds of millions of human beings.[4] Certainly, the host range among mammals is from the most primitive to the most highly developed. Verified cases of toxoplasmosis in animals have been reported from almost all parts of the world, not only among wild animals such as hares, rats and pigeons but also among such frequent pets as dogs and cats and in domestic animals such as pigs, cattle, sheep, rabbits and chickens. The widespread occurrence of the parasite among animals living in close contact with man provides rich possibilities for infection and is of epidemiologic importance.[5] Cole and his associates[6] established an association between Toxoplasma - shedding chronically infected pet dogs and the occurrence of proved human infection, thus pointing, as have numerous investigators, to animals as a probable source of toxoplasmosis in man. A large percentage of some normal adult population groups shows antibodies to Toxoplasma. A study in England disclosed by the dye test the presence of Toxoplasma antibodies in titers of 1:4 or more in 24 per cent of a sample of the adult population of Sheffield; in veterinary surgeons, abattoir workers and rabbit trappers they were especially high.[1,7] The mode or the multiple modes of transmission, however, remain one of the numerous puzzling features of Toxoplasma as yet unsolved.

Epidemiologic data on human toxoplasmosis indicate that the prevalence of the infection is highest in areas such as Tahiti and the coastal region of Guatemala, low in areas such as Iceland and Alaska, and higher in southern Sweden than in northern Sweden and in the coastal regions of Mexico than at the high altitude around Mexico City. In the United States there are regional differences in prevalence, with the eastern regions possibly showing higher rates than the western areas. Among the Navajo Indians in Arizona the rate is surprisingly low, while it is higher in their dogs. From these data, it appears that toxoplasmosis is more prevalent in warm moist areas than in cold areas or hot dry areas.[8]

Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 7, 1957.

This remarkably indiscriminate organism parasitizes many different types of cells as well as many hosts. Originally, many specific names were given to Toxoplasma from the various hosts, but biologic and immunologic studies indicate that these parasites are members of the same species, Toxoplasma gondii. In the acutely infected host, the parasite is widely distributed throughout the body. It has been found, in the late stages of acute infections, in the blood, urine, feces, milk, saliva, and serous exudates from the conjunctiva of various animals.

Congenital Toxoplasmosis

The most recent reports of investigators warrant the assumption that the congenital form of toxoplasmosis results when a nonimmune pregnant woman happens to acquire an infection which is usually inapparent. Infection of the fetus follows when the resultant parasitemia permits Toxoplasma to establish a nidus in the placenta. Holding this view, Feldman and Miller[9] advanced the hypothesis that the earlier in pregnancy the infection is acquired, the more catastrophic the effect. If the infection occurs early, a spontaneous abortion would result; if in the second trimester, a still birth or premature birth; if in the last trimester, a term birth with varying degrees of residual damage.

The infection may manifest itself in utero, or the infant may appear normal at birth, giving no sign of abnormality until characteristic physical or behavioral changes are observed after a period of days or even months. Active toxoplasmic infection in the newborn infant may produce rash, fever, jaundice, hepatosplenomegaly, convulsions, and encephalomyelitis with xanthochromic spinal fluid.[9,10] Chorioretinitis may or may not be present at birth, but develops in the great majority of the survivors after varying periods of time. Other effects which may accompany the congenital disease, and which not infrequently follow it during infancy and childhood, are hydrocephaly, microcephaly, convulsive disorders and psychomotor retardation. Cerebral calcifications are demonstrated in a high percentage of the cases. In his study of 103 children with the disease, Feldman[11] reported cerebral calcifications in 63 per cent, psychomotor retardation in 56 per cent, hydrocephaly or microcephaly in approximately 50 per cent, and convulsive episodes in about 50 per cent. Chorioretinitis, present in 99 per cent of the cases, was the most frequent finding. In 75 toxoplasmic infants studied by Eichenwald,[11] only 40 per cent had chorioretinitis when first seen, but the percentage increased to approximately 80 per cent when the survivors were subsequently examined.

In 187 cases of congenital toxoplasmosis recently analyzed by Feldman and Miller,[9] the children were four years of age or less in 119 of 176 cases, half of these one year or less; five to nine years in 38 cases, and 10 to 19 years in 19 cases. Most of the mothers were between 18 and 29 years of age. These authors suggested a possible relationship between the young maternal age and an age group of increased susceptibility to the disease and commented that these data could be interpreted as opposing the concept that infected infants often are born some years after the mother has acquired her initial infection. The sex incidence was approximately equal in this series. There were premature births in one fourth of 141 cases of the series, a figure somewhat but not greatly in excess of normal expectation. Some 20 per cent of the premature infants and 7 per cent of those born at term died, a difference in survival no greater than generally expected. In 82 per cent of the cases with associated chorioretinitis, there were lesions in both eyes, the bilateral involvement suggesting that the chorioretinitis results from blood stream seeding. Residual damage varied in degree, although in most of the cases there were detectable chorioretinitis, cerebral calcifications, mental retardation and/or disturbances in head size. Not every infant or child, however, with chorioretinitis or cerebral calcifications has congenital toxoplasmosis. This infection accounts, in general, for no more than half of such cases.

Is it likely that the mother of an infant with congenital toxoplasmosis will produce another such baby? On the basis of clinical and serologic findings, it has been assumed that congenital infection occurs only when the mother acquires the infection during the gestation period. "It appears justifiable," Jacobs[8] observed, "to assert that except under unusual circumstances there is little likelihood of a mother giving birth to more than one toxoplasmic child in separate pregnancies. This is supported by the histories gathered by Eichenwald and Feldman on the mothers of toxoplasmic infants." Summarizing their observations, Feldman and Miller[9] concluded: "The disease occurs as an accidental complication of an inapparent primary toxoplasma infection of

a pregnant female because such infections may be accompanied by parasitemia. In so far as we are aware, all such infants suffer some residual damage, but most survive. The infection may be acquired in any season of the year, and human-to-human transfer is not commonplace. This complication is not repeated in subsequent pregnancies, and it affects more than one offspring only if the reference pregnancy results in multiple births."

A suggestive complicated picture of this type is presented in a case of congenital toxoplasmosis reported in my recent series.[1] The infection was diagnosed when a white infant aged four months was first examined in October 1953. The child was re-examined in March 1956 at the Walter Reed Army Medical Center. At that time, the reaction to the Sabin-Feldman dye test was positive in a titer of 1:65536, the highest ever recorded there, and in the mother the titer was 1:4096. The twin brother of the mother has been under my care for some time with a discrete central macular lesion in one eye of long duration. His reaction to the dye test and the intracutaneous toxoplasmin test has repeatedly been negative.

In considering the disease manifestations that may accompany toxoplasmosis, it is particularly noteworthy that the majority of infections pass unnoticed.[12] Only rarely does a mother recall symptoms of infection, even though she may have given birth to an infant with the disease, apparently transmitted in utero. Feldman and Miller[9] found it impossible to detect any illness pattern during pregnancy suggestive of when the mothers might have acquired their infection because four fifths of the mothers denied having had any illness. It remains largely for the future to reveal adequate means of detecting the disease in the mothers and a method of treatment that will prevent the development of toxoplasmosis in the child.[13] Present therapy, however, seems to offer a beginning if there is any indication of maternal infection during pregnancy and the obstetrician is alert to the possibilities.

The anomalies resulting from congenital toxoplasmosis, therefore, may well be added to the large and growing list of acquired congenital defects that pose a problem in preventive medicine. Ingalls[14] recently stressed that the field of acquired congenital anomalies emerges as of equal stature with genetics itself and should be attacked on a combined front with the threefold forces of laboratory, clinical, and epidemiologic methodologies. He advocated application of the same degree of energy in combating this problem that has been used in conquering diphtheria and smallpox and is being directed at poliomyelitis. "The implication," he predicted, "of all that is known of maternal rubella, syphilis, toxoplasmosis, and influenza; of the effect of thiouracil, lead, or carbon monoxide poisoning during pregnancy; of diabetic, hematological, circulatory, and dietary disturbances; and of traumatic, radiation, and hypoxic diseases of the mother, placenta, and embryo is that many, if not most, congenital anomalies will be eventually brought under control as appropriate scientific studies clarify causes."

Acquired Toxoplasmosis

In contrast to several hundred accumulated cases of congenital toxoplasmosis recorded in the literature, reports of clinical toxoplasmosis acquired after birth are relatively few. The first two well substantiated cases were reported in 1941. Since then, reports indicate that in the proved cases of acquired toxoplasmosis the severity of the illness has varied from a mild, one day febrile illness with local adenopathy and no other distinguishing clinical features to a fatal, widely disseminated infection with a rickettsiosis-like rash, encephalitis, myocarditis and polymyositis.[15] Brown and Jacobs[16] recently reviewed the reported cases and in summation stated that acquired nonfatal toxoplasmosis may be manifested by a relatively mild syndrome simulating infectious mononucleosis, as well as by more severe symptoms grading into those found in the recorded fatal cases.

The acquired infectious disorders caused by Toxoplasma organisms are classified by Siim[5] as typhus-like exanthema, meningoencephalitis, chorioretinitis and lymphadenopathy. The exanthematic form of acquired toxoplasmosis is characterized by a typhus-like illness, often of acute onset, with chills and elevation of temperature to 104 F., preceded in some instances by fatigue and malaise of several days' duration. Typically, a red, nonhemorrhagic, maculopapular exanthema involves the entire body except the scalp, the palms, and the soles of the feet. Appearing at the earliest on the fourth day of the first week, the rash disappears one to two weeks later. A dry cough and pulmonary changes, simulating atypical pneumonia, usually are present both early and later, but may be absent. Symptoms

and signs of myocarditis and meningoencephalitis are frequent complications; there may be lymphadenopathy, but enlargement of the spleen has not been demonstrated. Most cases of this type have terminated fatally, and at autopsy cell infiltration and necrotic foci are present in the heart, lungs and central nervous system, with Toxoplasma-like structures in the myocardium.

A second grave manifestation of the acquired type is meningoencephalitis. Although it apparently occurs seldom, it has been reported from Denmark in a three year old girl, from North Africa, where strains were isolated from three adults, from the United States in two six year old boys, and also from Germany. Fever, delirium, generalized convulsions, lymphadenopathy and a mononuclear pleocytosis featured Sabin's fatal case in a six year old boy, the first to be reported, and at autopsy a meningoencephalitis was present, and the RH strain of Toxoplasma was isolated from the brain. Feldman's case was also in a six year old boy.

The first verified case of acquired ocular toxoplasmosis was reported in 1954 by Jacobs, Fair and Bickerton.[17] Toxoplasma organisms were isolated from an enucleated eye of a 30 year old man with chronic chorioretinitis.

While these three manifestations occur infrequently, acquired toxoplasmosis with a lymphadenopathy as the chief sign is diagnosed with relative frequency. Siim[5] divided this form into febrile lymphadenitis, a nonfebrile form, and a subclinical form. In the first subgroup, the onset may be acute with chills and elevation of temperature to 102 to 104 F., with the fever lasting for two to four weeks or longer and then decreasing by lysis; in the second, the enlarged lymph nodes are often discovered by the patients themselves, or by their mothers; and in the third, the lymphadenopathy is discovered in the course of routine examination.

In this milder nonfatal form, except for the lymphadenopathy the clinical examination is often normal. The enlarged lymph nodes, of hazelnut to walnut size, may be tender during the first weeks of the disease, but are usually painless later. The firm, discrete nodes, with smooth surfaces, are not attached to the underlying tissue. The covering skin is unaffected and does not itch; necrosis or formation of fistulas has not been observed. The lymphadenopathy is often generalized, with swollen nodes present in the suboccipital region, in the neck, in the axilla, and in the groin. It may be, however, that the lymph nodes are affected in one superficial area only. There may be enlargement of the hilar shadows. The spleen is seldom palpable. The clinical course is usually benign, with complete recovery in most instances. The enlargement of the lymph nodes, however, may persist for six to 12 months or longer, and there may be pronounced fatigue over a period of months.

Not only is the great variability of the manifestations of adult toxoplasmosis particularly noteworthy, but also the rarity of its recognition in contrast to the apparently widespread occurrence of the causative parasite among animals throughout the world. Epidemiologic studies have demonstrated that antibodies and skin sensitivity to Toxoplasma rise with increasing age, thus indicating continued acquisition of inapparent toxoplasmosis in the adult population and suggesting rather frequent occurrence of the disease in adults, but with symptoms so inconspicuous as rarely to permit clinical diagnosis. That it may be acquired in adulthood further substantiates the accepted concept that congenital toxoplasmosis is acquired in utero when the infection is present in the pregnant mother.[15]

Unfortunately, the maternal toxoplasmosis which is transmitted to the offspring with such distressing sequelae is usually of a subclinical nature, eluding diagnosis. Nevertheless, detection of acquired toxoplasmosis in pregnancy remains at present the only possible way of preventing the tragic cases of congenital toxoplasmosis in which the severe damage to the brain and the eyes is irreparable and for which no specific therapy has as yet been devised. In pregnant women, therefore, who show evidence of inexplicable fever, lymphadenopathy or excessive fatigue, a thorough examination should be carried out.

Ocular Toxoplasmosis

The commonest ocular manifestation of congential toxoplasmosis is a necrotizing chorioretinopathy, rather extensive in type, usually involving the central area, that is, the macula or paramacular region, and leaving deep scars. As a rule there are multiple foci. Coloboma of the choroid may be present,[18] as in one case in my first series. When the lesion becomes quiescent, much pigment migration and deposition take place. Rarely, anterior uveitis may occur, but in my opinion it is more prevalent in the adult form of the disease. Other ocular changes include microph-

thalmus, pupillary membranes and congenital cataract, all of which could, of course, be coincidental.

Duke-Elder[18] observed that the common infantile type may be associated with a toxoplasmal encephalitis which may be characterized by head retraction, facial palsy, conjugate deviations and absence of the pupillary and vestibular reflexes. Among the sequelae he mentioned hydrocephaly, areas of cerebral calcification, mental retardation and searching nystagmus. Certainly, chorioretinitis particularly in association with cerebral calcification, hydrocephaly or microcephaly, and psychomotor disturbances is highly suggestive of toxoplasmosis, and in the presence of these manifestations, the incidence of serologic confirmation of the diagnosis can be as high as 80 or 90 per cent.[19] It is, in fact, the most important sign for the detection of toxoplasmosis in patients in whom the disease may be suspected as the cause for congenital cerebral damage. Recently, Deutsch and Horsley[20] reported a fatal case in a newborn infant in which the ocular lesions were a prominent feature.

Chorioretinopathy may not be apparent at birth, but the characteristic lesions frequently develop within a few weeks. Although the macular region is most frequently involved, in some instances the lesions are located far out in the periphery of the retina. It may not be possible to see them except under full dilatation of the pupil and most complete funduscopic examination, which in children may be accomplished only under general anesthesia. In my experience, the lesions in a number of cases were in the extreme periphery and difficult to locate.

In acquired toxoplasmosis, the ocular manifestations may be suggestive, but they are not strikingly characteristic. In the proved fatal cases and the reported nonfatal adult cases, only an occasional instance of ocular involvement is reported.[21] Feldman[22] was able to demonstrate Toxoplasma antibodies in only 18 of 140 suspected cases of postnatally acquired toxoplasmic chorioretinitis. The so-called focal choroiditis, according to Woods,[21] is the lesion most frequently encountered. Approximately one half of such lesions apparently are attributable to acquired toxoplasmosis, quite similar lesions being caused by other infectious granulomata, notably tuberculosis and brucellosis. Next in frequency is a generalized granulomatous uveitis, quite indistinguishable in its appearance and course from chronic tuberculous uveitis. Other ocular lesions mentioned by Woods[21] are retinal periphlebitis with vitreous hemorrhages and possibly an acute optic neuritis. He stated that the rare systemic symptoms of acquired adult toxoplasmosis—fever, a generalized lymphadenopathy, nonspecific catarrhal symptoms, occasionally a pneumonitis, hepatitis, an exanthematous rash or a meningoencephalitis, and sometimes a blood picture suggestive of infectious mononucleosis—rarely, if ever, occur in association with ocular lesions. Duke-Elder[18] noted that the disease in the adult "is usually subclinical in its manifestations, but the evidence that it may give rise to a necrotizing chorio-retinitis or a generalized uveitis of a very recalcitrant type resembling tuberculosis in its clinical and pathological characteristics is rapidly growing." McKinney[23] recently reported a case of presumptive toxoplasmic iridocyclitis in an adult with apparent response to specific therapy.

The course of the acquired ocular disease was described in a recent comment in these words: "In verified toxoplasmosis involving the eye there may be a history of acute retinitis or, less often, of uveitis, or the inflammatory process may develop gradually. Characteristically, in acquired, as distinguished from congenital, infections, it tends to become chronic as the involved cells change their role from host to that of phagocyte, with corresponding decrease in multiplication of Toxoplasma organisms and frequently their inclusion in pseudocysts. From these pseudocysts the infection may later become reactivated."[22] Jacobs[8] regarded the brain and the eye as the most frequent sites of persistence of the parasites in animals and probably in man. He observed that possibly because of low immunity in the ocular fluids and tissues, rupture of pseudocysts and proliferation of parasites may occur from time to time, resulting in exacerbations of chorioretinal lesions. Hogan, Zweigart and Lewis[24] recently demonstrated experimentally the persistence of Toxoplasma in ocular tissue.

Diagnosis

The most commonly recognized clinical manifestations of human toxoplasmosis are the results of congenital infection. Even though the clinical picture is more or less characteristic, neither the manifestations of damage to the nervous system, which are most frequent, nor those involving the viscera, such as neonatal jaundice or hepatosplenomegaly, are sufficiently definite to permit a diag-

nosis on clinical grounds alone. The clinical diagnosis must be confirmed by positive serologic tests.[19] Likewise, the clinical features of acquired toxoplasmic infection are by no means characteristic for this disease exclusively. The preliminary clinical diagnosis can be substantiated only in the laboratory "by the demonstration of Toxoplasma antibodies in paired blood samples, and by the isolation in clean laboratory mice or tissue culture of the parasite from blood, spinal fluid, lymph node or muscle biopsies, or from specimens obtained postmortem."[5] Morever, in the absence of a characteristic ocular symptomatology and concomitant systemic manifestations, with no adequate therapeutic trial test, and with no ocular tissue available for isolating or culturing the parasites, the diagnosis of adult ocular toxoplasmosis must rest on various diagnostic tests which reveal an antibody response to the infection.[21]

It was not until 1948 that the dye, skin and complement-fixation tests became available and served to stimulate worldwide interest in Toxoplasma. Recently, Eichenwald[25] discussed the laboratory diagnosis of toxoplasmosis and declared the Sabin-Feldman dye test to be undoubtedly the most useful tool in the diagnosis of Toxoplasma infection. Eyles[13] regarded this test as a milestone in the history of toxoplasmosis of the greatest importance in dealing with this disease, in which it is so difficult to isolate the actual etiologic agent. This test and the titer strength considered diagnostic, additional laboratory procedures, notably the complement-fixation and the toxoplasmin cutaneous tests, and other aspects of laboratory diagnosis will be presented in the discussion by the distinguished pathologist, Dr. James N. Patterson.

Treatment

The difficulty in diagnosing toxoplasmosis and the lack of drugs of demonstrated value have hampered the treatment of the disease. Recently, however, as the role of toxoplasmosis in causing granulomatous uveitis, chorioretinitis, and the syndrome characterized by lymphadenopathy and fever has been more fully realized, animal experimentation has led to the discovery of agents effective against the disease in animals. These drugs give promise of being effective in man, and reports of their use in the treatment of human toxoplasmosis are just now becoming available.

Two groups of drugs offer promising activity: (1) the sulfonamides, the most active of which are the sulfapyrimidines (sulfamethazine, sulfamerazine, and sulfadiazine) and sulfapyrazine; and (2) the 2,4′-diamino pyrimidines, the most active of which is pyrimethamine (Daraprim). Among the sulfones, the antibiotics and other groups, less active compounds have been found.[26]

While they are of value individually, perhaps the outstanding feature of the sulfonamides and pyrimethamine is their synergistic action. In his recent review of the newer knowledge of the chemotherapy of toxoplasmosis, Eyles[26] concluded that these drugs act together synergistically most likely by imposing sequential blocks upon the metabolic pathway involving para-aminobenzoic acid, folic acid, and folinic acid. Because of this synergistic action it is possible to obtain chemotherapeutic effect with much lower dosages than with the drugs individually. This author observed that the reports [23,27] now appearing describing the use of the sulfonamides and pyrimethamine in human toxoplasmosis, while difficult to evaluate, nevertheless appear to indicate that activity against both acute acquired toxoplasmosis and toxoplasmic uveitis and chorioretinitis is becoming reasonably well substantiated. My experience with this therapy adds evidence in support of this observation.

Review of Cases

In a recent presentation,[1] I reported a series of 14 cases believed to be of toxoplasmic origin and discussed the various aspects of the problem of ocular toxoplasmosis. In this series, the diagnostic criteria were a characteristic ocular picture, a careful search for other sources of uveitic infection, and the presence of a positive reaction to the intracutaneous toxoplasmin test and the Sabin-Feldman dye test in each case. In two cases of the series the reaction to the dye test was positive in a titer of 1:32; in six, 1:64; in two, 1:126; in one, 1:128; in one, 1:256; in one, 1:512 and later 1:65536; and in one, 1:16384. In five of the cases the controversial question could be raised regarding the possibility of skin testing causing an anamnestic rise in the dye titer, a subject Dr. Patterson will doubtless mention, along with the titer considered diagnostic, in the discussion of this paper.

In this first series, most of the cases were characterized by an acute flare-up of the disease, particularly in the posterior portion of the uvea, superimposed on previously existing lesions. The patients ranged in age from four months to 70 years; more than half, however, were in the late teens or in the twenties. Nine were females, and five were males. Arrest of the infection and, in 11 of the 14 cases, some improvement in vision resulted from the use of Daraprim and sulfonamide therapy. In a few cases the visual results were dramatic.

The first case of this series illustrates the remarkable response to systemic antitoxoplasmosis therapy during an acute attack of uveitis, with probable salvaging of useful central vision in the one functioning eye. In this case, long-standing recurrent posterior uveitis with binocular evidence of posterior fundal lesions typical of toxoplasmosis has been observed by me since 1949 in a patient then aged 18 with a history of poor vision for 10 years prior to that time (figs. 1 and 2). In January 1957, this patient, after a normal labor, gave birth to her first child. The obstetrician



Fig. 1.—This view shows one of the lesions located in the macula of the left eye, active in 1949 and not controlled sufficiently to prevent loss of central vision.



Fig. 2.—Chorioretinopathic scar of minor nature in the left eye resulting from an active process in 1955, controlled apparently completely by pyrimethamine and sulfonamide therapy.

reported that the infant was apparently normal in all respects.

In a second case with prompt response to accepted therapy, a robust 17 year old girl complained in April 1956 of a film over the left eye for several days. The mother had required intravenous feeding much of the time during the pregnancy. In the right eye there were multiple inactive lesions of choroiditis with marginal pigment and in the left eye much vitreous exudate with many fundal scars, two of the lesions being active (figs. 3 and 4). Physical examination, including roentgenograms of the chest and skull, and the usual tests gave negative results except the intracutaneous toxoplasmin test, to which the reaction was strongly positive with perhaps some focal and general reaction also. There was a positive response to the Sabin-Feldman dye test in a dilution of 1:512. Under treatment with Daraprim and Combisul (3) the eye quieted down within four weeks. In July renewed activity in this eye ceased and the following month activation of a lesion in the right eye subsided promptly on resumption of the treatment. There has been no further activation of the lesions in the uveal tract. With this therapy, definite improvement in the emotional pattern was noted in this case and in several other treated cases.

The present series of six cases represents additional instances of ocular involvement of presumptive toxoplasmic origin. The patients ranged in age from three and one-half to 37 years; five were females and one male. In all of these cases the Sabin-Feldman dye test gave a positive result in dilutions ranging from 1:128 to 1:1024.

Report of Cases

Case 1.—A white woman, aged 37, complained in 1934 of impaired vision in the right eye for five months, which had rapidly become worse during a period of three weeks immediately prior to consulting me despite energetic treatment elsewhere. On examination, global injection, a considerable number of flat keratic precipitates, vitreous opacities obscuring a good view of the fundus and some lenticular pathologic changes of a secondary posterior subcapsular type were noted in the right eye. Bare light perception was present in this eye. There was little change in the iris. The left eye appeared normal in all respects. The reaction to the intracutaneous tuberculin test was positive, and old tuberculin therapy was given off and on until the response to this test was negative.

The patient was not seen from 1937 until she returned in 1948. At that time the right eye was white and quiet; posterior synechiae, atrophy of the iris and pronounced secondary lenticular opacification were present, as were good light perception and projection, and macular and color perception. There were a few inactive flat keratic precipitates in this eye. The intraocular pressure was 22 Schiøtz. In September, a combined intracapsular extraction was performed with satisfactory improvement in the eye during several months' observation postoperatively. A quiet but extensive area of chorioretinitis could be made out on the temporal side, midway between the disk and the per-



Fig. 3.—Discrete scars of chorioretinopathy in the periphery of the right eye.



Fig. 4.—Extensive scarring to the nasal side of the disk. There was activity in this area during the course of observation. The process quieted down promptly on pyrimethamine and sulfonamide therapy.

riphery. With an aphakic lens, the vision in this eye corrected to 20/50 at distance with a Jaeger 3 at near.

The situation remained satisfactory until 1956 when there was activation of the process in the right eye with a considerable number of vitreous floaters and some bleeding in and around one of the larger lesions temporally. Prior to this episode there had been slight intraconjunctival bleeding in the left eye. Complete laboratory tests gave negative results, and the Rumpel-Leede sign was absent. The intracutaneous tuberculin and toxoplasmin tests gave negative results, but the reaction to the Sabin-Feldman dye test was positive in a dilution of 1:1024. The administration of Daraprim, 25 mg. daily, sulfadiazine four times daily, Sodium Sulamyd drops in the eye and a sulfathiazole ointment on retiring resulted in complete subsidence of the active process within a period of several weeks.

In this case a patient with a monocular lesion had a uveitis in 1934 of the anterior as well as the posterior type requiring cataract surgery. Following a flare-up in 1956, there was complete subsidence of activity on Daraprim and sulfonamide therapy. The question arises as to whether or not there was infection caused by Toxoplasma right from the beginning.

Case 2.—A white girl, aged three and one-half years, was first seen in 1944. There was a history of dancing eyes and poor vision since birth. Delivery at term was normal. The mother stated that the child could not hold up her head and that she had had an undetermined course of fever. An older brother and sister were normal children.

Except for an inclination to a head nod, the general physical examination, including roentgenograms of the skull, gave negative results. In the left eye, there was a pronounced focusing nystagmus with an internal squint of about 35 prism diopters with apparently limited external rotation and greatly increased internal rotation. Funduscopic examination revealed inactive but prominent scars of central chorioretinopathy with much pigment migration and pallor of the disk in the left eye. The reaction to the intracutaneous tuberculin test and the test for brucellosis was negative. Muscle surgery was performed.

The child was not seen again until 1947, when the pronounced focusing nystagmus was still present. The eyes were practically parallel. The vision was 20/200 in the right eye and 10/200 in the left eye with about the same funduscopic findings. Again, the intracutaneous tuberculin test and the test for brucellosis gave negative results.

The patient was seen periodically until 1956. At that time the Sabin-Feldman dye test gave a positive response in a dilution of 1:512, and the reaction to the intracutaneous toxoplasmin test was markedly positive. An operation was performed for nystagmus in which the eyes were placed in the direction of the quick component by resection of the external rectus of the right eye and resection of the internal rectus of the left eye, with much improvement in the nystagmus and perhaps some visual improvement. Therapy with Daraprim once daily and 0.5 Gm. of sulfadiazine twice daily had to be discontinued after a period of six weeks because of a secondary anemia of considerable degree.

At the time of the last examination on Jan. 21, 1957, the vision was 20/200 plus in the right eye and 20/200 in the left eye. The visual fields were markedly contracted, particularly in the left eye, with central scotomata in both eyes. There was great improvement in the general condition, and both to the family and to me there seemed to be improvement in the various nervous manifestations on the Daraprim and sulfadiazine therapy. The bone marrow depression disappeared completely without too much medication.

In all probability, this child had had a toxoplasmic infection from birth. On her record card I had noted in 1948 that toxoplasmosis was to be considered, but at that time I was not well enough informed to make the diagnosis.

Case 3.—A white girl, aged 16, an only child, was first examined in 1939. There had been a loss of vision in the left eye for about one year. Delivery at term had been normal although the mother had been ill during the pregnancy. The child seemed to be normal at birth. On ocular examination, the right eye appeared normal in all respects. In the left eye, anteriorly there were a few more or less quiescent keratic precipitates. It was difficult to obtain a view of the fundus. There were multiple areas of choroiditis in the central region to the temporal side with many vitreous opacities, thinning of the vitreous structure and secondary posterior subcapsular lens opacity. The vision in the right eye was 20/30 plus and in the left eye 10/200. The intracutaneous tuberculin test and also the test for brucellosis gave negative results.

The patient was not seen again until 1956. In the interim, she had married and now had two children living and well, but had had three miscarriages prior to the birth of these children. She complained of nausea, headaches, nervousness and at times emotional disturbances. The right eye showed some scarring to the temporal side with pigment migration rather far out toward the periphery, multiple scars above and much pigment, a considerable number of vitreous floaters and also scars of a chorioretinopathy in the periphery below with much pigment. In the left eye, a mature lens opacity was present with no view of the fundus obtainable. The intracutaneous tuberculin and brucellergen tests gave negative results, but the reaction to the intracutaneous toxoplasmin test was markedly positive. The Sabin-Feldman dye test gave positive results in a dilution of 1:128. The general physical examination, including roentgenograms of the skull, gave negative evidence.

The treatment consisted of Daraprim once a day, 0.5 Gm. of sulfadiazine twice daily, and Sodium Sulamyd drops and sulfathiazole ointment locally in the eyes. Nicotinic acid was prescribed by mouth along with sublingual histamine. There was careful laboratory supervision to guard against bone marrow depression. During the four months since this therapy was begun, there has been considerable improvement in the vitreous opacities in the right eye. The condition of the left eye remains about the same. There is great improvement in the general condition with decrease of the nervous symptoms.

In all probability, this is a case of congenital toxoplasmosis. In 1957, the Sabin-Feldman dye test gave negative results in the two children.

Case 4.—A white woman, aged 35, had a central active elevated lesion of a chorioretinitis in the right eye when she first consulted me in 1953. The left eye appeared to be normal. The intracutaneous tuberculin and brucellergen tests gave negative results. A general physical examination, including roentgen examination of the teeth and one extraction, was carried out. Routine treatment was instituted with the lesion in the right eye quieting down and remaining so until 1957, when some reactivation of the area occurred. At that time, the reaction to the intracutaneous tuberculin and brucellergen tests was negative, but positive to the intracutaneous toxoplasmin test with vesiculation. The response to the Sabin-Feldman dye test was positive in a dilution of 1:512. Daraprim once daily and Combisul twice a day were prescribed. The eye quieted down with no other measures, the lesion became highly discrete, and there was a residual vision of 20/200 minus.

Whether or not this monocular lesion, observed from 1953 to the present time with a prolonged period of quiescence followed by reactivation in 1957, was toxoplasmic in origin is problematic despite the positive reaction to the intracutaneous toxoplasmin test and to the dye test in a dilution of 1:512.

Case 5.—A white man, aged 24, first consulted me in 1930. Posterior uveitis of considerable degree was present, particularly in the left eye with some activity in this eye. The vision in the right eye was 20/100 and in the left eye 5/200. He was seen rather frequently for

a time and then was referred to Dr. William Y. Sayad of West Palm Beach, as he lived in that area. He did not return until November 1956, at which time there was a history of complete loss of central vision in the left eye and vision always having been poor in the right eye. He had had considerable old tuberculin therapy given by Dr. Sayad.

In the fundus of the right eye there were multiple pigmented areas in the macula and paramacular region. Similar but much more extensive lesions with some elevation and heavy pigmentation were present in the left eye. There seemed to be some activity with a considerable amount of vitreous exudate in this eye. The vision was again 20/100 minus in the right eye and less than 20/200 in the left eye, not improved. Both the intracutaneous tuberculin and toxoplasmin tests gave moderately positive results, while the brucellergen test gave negative results. The reaction to the Sabin-Feldman dye test was positive in a dilution of 1:1024.

With the institution of treatment consisting of old tuberculin therapy, Daraprim once daily, Combisul twice daily and a multiple vitamin, the left eye quieted down with complete inactivation of one lesion that was certainly active. In addition to the home treatment, there has been some office therapy with streptomycin and Sodium Sulamyd iontophoresis. The vision has improved little, of course, but there has been some general improvement, particularly noted by the family.

In this case with a positive reaction to the intracutaneous tuberculin test, the question arises as to whether there is present a tuberculoprotein sensitivity, a toxoplasmic infection, or a combination of the two. Certainly, the patient has recently been doing well on the accepted therapies for each, instituted at the same time.

Case 6.—A white woman, aged 21, had a spot on the left eye and poor vision in this eye when she first consulted me in July 1953. Examination revealed multiple areas of choroiditis in the macula and paramacular region, with much pigment in the central lesion, and some pallor to the temporal side of the disk, probably associated with a retinitic optic atrophy. The vision in this eye was 2/200. The right eye was normal with a vision of 20/20. The intracutaneous tuberculin and brucellergen tests gave negative results.

The patient was not seen again until 1956, when the situation was about the same. The reaction to the intracutaneous tuberculin and toxoplasmin tests was moderately positive, and negative to the brucellergen test. The Sabin-Feldman dye test gave a positive result in a dilution of 1:128. The general physical examination, including roentgenograms of the skull and chest, gave negative results. Therapy consisted of Distrycin injections, Daraprim once daily, 0.5 Gm. of sulfadiazine twice daily, Sodium Sulamyd drops in the eyes twice daily and a sulfathiazole ointment at night. The ocular situation remains about the same. Inasmuch as there were no general complaints, there is no yardstick to follow as to whether or not there was improvement in the general condition.

A monocular involvement of chorioretinopathy due to toxoplasmosis possibly may be present in this case, and it may be that a tuberculoprotein sensitivity also is present.

Summary

The clinical aspects of toxoplasmosis in its congenital, acquired and ocular forms are presented, and the salient features of the causative parasite, T. gondii, are reviewed. During the few years that this organism has been recognized as being capable of producing fatal human congenital disease and giving rise to inapparent infections in human adults, the disease has become the concern of the obstetrician, the pediatrician, the general practitioner, the internist, the ophthalmologist and the pathologist as well as the parasitologist.

Congenital toxoplasmosis is a pediatric problem with the responsibility for early diagnosis obviously resting on the obstetrician and the pediatrician. It occurs when a nonimmune pregnant woman acquires a usually inapparent infection, which, through resultant parasitemia, is transmitted placentally to the fetus, often causing irreparable damage to the central nervous system. The obstetrician's alertness to the clinically insignificant symptoms of this infection in the pregnant patient, coupled with prompt therapy, may be the means of preventing the serious and at times fatal manifestations in the infant. Only in this way can sufficient data be accumulated to chart progress in dealing with this acquired congenital disease and its dread manifestations.

The pediatrician must cope with the residual damage of the congenital infection and recognize its origin. The chief benefit to be derived from a specific diagnosis of congenital toxoplasmosis is the good prognosis for subsequent children. There appears to be no adequate evidence that a mother can give birth to more than one child with the disease.

In the acquired form, the illness may vary in verified cases from a mild one day febrile illness with local adenopathy the only distinguishing feature to a fatal widely disseminated infection. Epidemiologic data suggest that the disease occurs rather frequently in adults, but is rarely recognized because the inconspicuous symptoms seldom permit clinical diagnosis. A high index of suspicion on the part of the general practitioner and the internist, as well as the obstetrician, would help to meet the challenge of this form of the disease. The actual recognition of both the congenital and the acquired forms depends upon clinical awareness quite as much as upon diagnostic facilities.

The ocular form of the disease constitutes perhaps its most important human manifestation. The determination of the important role of toxoplasmosis in both infantile and adult uveal inflammation offers an excellent example of cooperative endeavor between the parasitologist, the ophthalmologist and the pathologist. Chorioretinopathy is the commonest manifestation of congenital toxoplasmosis and is the most important sign for the detection of the disease in

patients in whom it may be suspected as the cause of congential cerebral damage. Focal choroiditis is the lesion most frequently encountered in adults. Systemic symptoms of acquired adult toxoplasmosis rarely occur in association with ocular lesions.

Six cases are reported which, added to an earlier series, illustrate the importance of clinical awareness of the disease on the part of the ophthalmologist.

In congenital, acquired and ocular toxoplasmosis, the preliminary clinical diagnosis must be confirmed in the laboratory by serologic tests. The Sabin-Feldman dye test is the most useful diagnostic measure.

Sulfadiazine and pyrimethamine constitute the accepted therapy at the present time. Their synergistic action produces chemotherapeutic effect with much lower dosages than is obtained with the drugs individually.

Clinicians are urged to add their experience with this curious parasitic disease to the accumulating data so that clarification of its puzzling aspects may be expedited.

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Discussion

DR. JAMES N. PATTERSON, Tampa: There can be no doubt but that Dr. Forbes' paper represents an outstanding clinical contribution in the elucidation of a disease process which not too many years ago was practically unrecognized. It represents, too, the expenditure of a great deal of time and energy over and above that of the routine practice of ophthalmology.

The procedures available in the laboratory diagnosis of toxoplasmosis fall into three main categories: (1) isolation of the organism, (2) serologic tests and (3) toxoplasmin skin tests.

1. Isolation of the organism by tissue culture or animal inoculation and identification by morphologic and serologic studies would provide irrefutable evidence. This method, however, is not practical since material for study is usually not available; and if it were, only a few research laboratories would have the facilities and trained personnel necessary to carry out properly work of this type.

2. The main serologic tests are: (1) the dye test of Sabin and Feldman and (2) the complement-fixation test.

There is no doubt that the best test presently available for the diagnosis of all stages of Toxoplasma infection is the dye test. This test is based on the observation that both the cytoplasm and nucleus of the organism, when incubated with normal serum under conditions of the test, subsequently stain blue upon the addition of methylene blue; whereas, after exposure to antibody-containing serum under the same conditions, only the nucleus takes the stain. The test is technically difficult and requires the presence of a continuous source of living Toxoplasma.

This test becomes positive early in the course of the disease and remains positive for years, although in diminishing titer. Sabin and many other investigators believe that a positive dye test of any degree cannot be disregarded but that it must be correlated with the history, clinical findings and other laboratory data. Others, including Woods, because of the large number of apparently normal persons (Feldman found positive results in 77 out of 144 residents of Pittsburgh) who give a positive reaction to the dye test, the degree of positivity of which rises with advancing age, suggest the following titers be regarded as of diagnostic value:

Age	Titer
Under 10 years of age	1:8 or over
10-19 years of age	1:32 or over
Over 20 years of age	1:64 or over

It is easy, however, to visualize a patient with an allergic reaction to a single ruptured pseudocyst as having a very low titer.

Frenkel reported in 1948 that an anamnestic rise in titer of the dye test occurs after a toxoplasmin skin test.

Feldman, Woods, Jacobs, Fair and Bickerton have not found that such a rise takes place.

The complement-fixation test becomes positive only at a later stage of the disease and becomes negative before the dye test becomes so. Since many cases of toxoplasmosis have never exhibited a positive complement-fixation test, it is of limited value in diagnosis.

3. The intracutaneous test with toxoplasmin is a test analogous to the tuberculin test in method of administration and interpretation. A negative skin test does not rule out the disease since dermal hypersensitivity is usually absent in the acute stage of the disease and in infants with congenital toxoplasmosis before the age of nine months. A positive dermal reaction is usually associated with the presence of antibody.

Much investigation in this field is taking place. A new test based on hemagglutination is being performed by Dr. Leon Jacobs at the National Institutes of Health. It may eventually replace the dye test according to some authorities. Another test, a fluorescence inhibition method, is being investigated by Dr. Morris Goldman at the Communicable Disease Center of the U. S. Public Health Service at Chamblee, Ga.

In summary, one can state that the dye test becomes positive first, the skin test next, and then the complement-fixation test. In most cases of toxoplasmosis both the skin and dye tests will be positive. The complement-fixation test is confirmatory evidence, when positive. As in all laboratory procedures, however, there must be careful correlation of the history, physical findings and all laboratory data.

I again wish to compliment Dr. Forbes on this outstanding contribution.

Dr. Kenneth S. Whitmer, Miami: Dr. Forbes has described so beautifully and completely what is known of the disease that there is little left for discussion. I have followed only two cases of congenital toxoplasmosis in which the serum taken in both mother and child was significant, and in neither of these was the Eli Lilly toxoplasmin skin test antigen available, nor were other laboratory tests such as blood cultures, animal inoculation, complement-fixation tests or spinal fluid examinations made.

In one case both ocular and cerebral manifestations were present, while in the other they were purely ocular. Both patients survived; so no pathologic specimens were available. The ocular disease in both babies was bilateral and central. Both were treated by the drugs currently in use as described by Dr. Forbes, and in both, the residua were large central pigmented chorioretinal scars.

I have not reviewed my other cases of recurrent choroiditis in the light of the dye test, but have been using the skin test antigen for the past year or so on the basis of Frenkel's suggestion that the test is positive if an indurated area of 5 to 6 mm. is present with a surrounding erythematous area of some 10 to 20 mm. I realize, however, that the skin test alone does not diagnose toxoplasmosis.

In the absence of other clinical or laboratory causes of uveitis, the positive skin reactors were treated with Daraprim and sulfadiazine for fairly long periods of time. I have been a little disappointed in my results. One group reported a series of cases of uveitis in which all patients were given a course of Daraprim and sulfonamides, and they concluded that 25 per cent of the patients improved with this therapy. I have watched cases in which focal choroiditis flared up, reduced central vision to 20/100 or so, and then completely subsided with chorioretinal scarring with no treatment at all.

I should like further to point out that, as in all forms of chorioretinitis, the diagnosis of toxoplasmosis is usually presumptive and is made by the exclusion of other diseases, which is often impossible. I appreciate discussing Dr. Forbes' paper very much and am sure it will stimulate all of us when we are confronted with one of ophthalmology's most perplexing problems, the differential diagnosis of chorioretinitis.

Dr. Forbes, closing: I wish to thank Dr. Patterson and Dr. Whitmer for their excellent discussions.

I agree with Dr. Whitmer that the diagnosis of toxoplasmosis is somewhat presumptive and that other causes of chorioretinitis should be carefully excluded. Also, I concur in Dr. Patterson's report on the complement-fixation test. The reaction to this test is inconstant, it comes on later, it disappears earlier, and it is not persistent.

An important diagnostic point is the therapeutic test. The routine Daraprim-sulfonamide therapy is tolerated in a large percentage of cases of chorioretinitis without untoward effect. At the outset Daraprim, pyrimethamine and the sulfonamides were prescribed in fantastic doses, but my experience has led me to conclude that over the long course the proper medication is 25 mg. of Daraprim daily with a moderate dose of sulfonamides. Over a long period, the patients tolerate this dosage well. The one case of folic acid deficiency in my series was handled without difficulty. There have been some reports in the literature of severe reactions from the accepted therapy, hut the wise course, in my opinion, is to take it easy and remember that this therapy will have to be continued over a long period.

One particularly noteworthy point is that in order to prevent a possible anamnestic increase in titer of the dye test by the intracutaneous skin testing, the blood for the dye test is collected before the time of the skin testing.

Doctor: Your Opinion Is Needed

For the purpose of continuous improvement of The Journal of the Florida Medical Association, there is a questionnaire on page 277 of this issue to which each member of the Association should pay particular attention.

There is a place in the questionnaire for your opinion—on original articles, editorials and commentaries, news items, book reviews and other subjects.

It is urgently requested that you spare a few moments to fill in and return this questionnaire. It is your opinion that will guide The Journal into greater service to its readers.

Optimal Timing in Elective Pediatric Surgery

THOMAS J. ZAYDON, M. D.
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MIAMI

Any patient in need of elective pediatric surgery should be seen, by the surgeon, at the earliest possible time for individual evaluation. Though certain generalities can be made as to optimal age for surgery, it is conceivable that interval therapy of varied nature might well facilitate definitive repair. Surgical correction might, in some instances, be carried out at an even earlier date than is generally suggested. Needless to say, the child should possess sufficient vitality to withstand surgery. He should have a satisfactory blood picture; be free of any associated infection, jaundice or dermatologic problem; and be of satisfactory weight. The abnormality and the reaction of the family to the situation must also be fully evaluated. Whenever possible, correctable abnormalities should be treated in the preschool period. The child may then participate in various activities and be free of ridicule from playmates. Further, he will avoid loss of school time, especially when prolonged stage procedures are necessary.

Hemangioma

Hemangiomas must be carefully individualized and evaluated early in life if the proper therapeutic course is to be decided upon. True, many will regress; equally true, many will deform, or destroy vital structures, facial features, and even the patient himself. If the hemangioma is small, doing no harm by its presence, or is obviously decreasing in size, certainly no therapy is advocated. These lesions are, however, treated at the earliest age seen if they are increasing in size, or are prone to ulcerate, bleed, or become infected. One is at times justified in waiting six to 12 months only if the patient is closely supervised and the family fully cooperative. Needless to say, there is great esthetic benefit from removal of an unsightly lesion. In the ultimate course of possibilities, though granted to be remote, malignant change is avoided.

From the Department of Surgery, University of Miami School of Medicine, Miami.
Exhibit presented at the Eighty-Second Annual Meeting of the Florida Medical Association, Miami Beach, May 14-16, 1956.

Nevus

There is a variation as to the ideal age for correction of nevi, with special reference as to location, extent and exact nature. Generally, nevi are corrected at two to six years of age. All nevi which are subjected to chronic irritation, showing evidence of growth, increased vascularity, ulceration, change in color, or infection, should be removed. By removal, the presence of malignant disease will be ruled out and the possibility of ultimate malignant change will be eradicated. The appearance is improved by removal of these disfiguring lesions.

Inguinal Hernia

Inguinal hernias in infants and children should be repaired as soon as possible after they are discovered unless specific contraindications, such as prematurity, exist. While inguinal hernias may occasionally obliterate during the first few months after birth, this outcome should not be anticipated. The incidence of incarceration during the first year of life, with its serious implications, far exceeds the possibility of spontaneous cure.

Umbilical Hernia

Spontaneous obliteration of a small umbilical hernia is so frequent and incarceration is so uncommon that elective repair does not seem warranted unless the hernia persists after the age of one year. When a large hernia results in considerable irritability of the infant, elective repair should be performed sooner.

Hydrocele

Most of the hydroceles encountered in infancy will undergo spontaneous regression and will not require surgery. Surgical treatment should be considered if the mass is large and tense enough to cause discomfort, or if the hydrocele persists after the first year of life. If an accompanying hernia is discovered, the operation should not be delayed.

Undescended Testicle

The incidence of sterility is small and almost the same when one or both testicles are normally in the scrotum; therefore, the advisability of orchidopexy for unilateral cryptorchidism becomes a serious question. Bilateral cryptorchidism has better than a 90 per cent chance of sterility and should receive surgical attention if conservative measures fail. Orchidopexy is performed after the age of four years and always before the age of 10 if the probability of sterility is to be averted. Surgery also may be required to avoid trauma to an inguinal testicle or to correct an associated torsion of the cord. The relationship between cryptorchidism and malignant disease is unconvincing. Early surgery with orchidopexy is indicated when there is an associated hernia.

Hypospadias

Repair of hypospadias is generally initiated at four to five years of age; however, if there is a severe ventral curvature or underdevelopment of the penis of considerable degree, the first stage may be carried out at two years of age. This early repair, in the latter instance, will allow unrestricted development during the early growth years. Objectives in surgical intervention are: the release of ventral curvature; repositioning of the meatus; normal urination in the standing position, with a normal stream; normal intercourse and insemination. Of tremendous psychic value is the restoration of normal appearance and possible correction of incontinence and enuresis. Surgery at this age is facilitated by the presence of more working tissue, thus allowing a definitive, final type of repair. Undue mental anguish is avoided, especially the psychic trauma during school years. Further, priapism, which may complicate the surgery, is easier to avoid early in life. Of import also is the associated factor of impotency, which may possibly be avoided if surgical correction is carried out early. When the meatus is at or near the glans and there is minimal or no ventral curvature, no surgery should be performed.

Epispadias

In correcting epispadias, surgery is directed toward the correction of the dorsal cleft and the retraction of the penis. This is generally carried out at four or five years of age. The incontinence may be helped, and great mental satisfaction can be afforded the patient.

Exstrophy of the Bladder

Ureteral diversion is generally carried out at about two to four years of age and excision or revision of the bladder at four to five years of age. The objective in children with exstrophy of the bladder is to prevent recurrent, ascending infections of the kidney and an untimely death due to pyelonephritis. Surgery will eliminate the sensitive, bleeding, exposed mucosa; the urinary incontinence may be helped and the urinous odor avoided.

Thyroglossal Cyst, Sinus or Fistula

Correction of a thyroglossal cyst, sinus or fistula should be delayed until after two years of age unless a complication necessitates earlier intervention. Endotracheal intubation in early infancy is discouraged for elective procedures because of the increased incidence of postoperative laryngeal morbidity. Surgery should not be postponed too long, as there will be recurrent episodes of infection and troublesome drainage. These complications tend to add to the scarring and also to the difficulty of final corrective surgery.

Branchial Cyst and Sinus

Surgery for a branchial cyst and sinus should be carried out after one or two years of age, unless the size or symptom complex necessitates earlier intervention. Varied vagal symptoms such as vomiting, pallor, and uneasiness may be noted. There is always the possibility of recurrent inflammation and infection, especially at the time of an infection of the upper part of the respiratory tract. The persistent or repetitious discharge of mucus may be troublesome. The possibility of malignant change likewise should be borne in mind.

Cystic Hygroma

Surgical extirpation of a cystic hygroma should be carried out especially early in infancy if there is massive involvement, with difficulty in swallowing or breathing, or if there is rapid increase in size due to hemorrhage. Compromise of vital structures or infection may justify earlier intervention. Aspiration may well tide the infant over a critical period while awaiting more satisfactory conditions. Generally the child should be at least three or four months of age, or preferably, about two years of age prior to correction.

This rather extensive surgery is better tolerated and the anesthetic is more safely administered after the age of two years.

Torticollis (Wryneck)

Generally, one may allow three to six months for all possible chance of spontaneous improvement or correction of wryneck. Repeated examinations should be made, however, and the repair carried out at the age of six months, or earlier, if the deformity is severe or the distortion is becoming progressively worse, with increasing facial asymmetry. The objective of early surgery is to prevent distortion of cervical and facial bones and pronounced shortening of skin, fascia and muscles in the course of growth. An early repair will prevent a permanent deformity by avoiding bony distortion over the many years of growth and eliminate the typical slanted deformity and asymmetry of the face. Freer movement of the head is allowed. If a definite deformity has occurred, optimum conditions for restitution of facial and cervical structures will be established.

Megacolon

The infant with congenital megacolon will usually show signs of constipation, abdominal distention and partial intestinal obstruction from the first days of life. When the condition cannot be controlled medically during the early months, a temporary colostomy may be indicated before a curative operation is performed at the age of one year or older. Usually the aganglionic segment at the rectosigmoid and colon is resected with restoration of intestinal continuity at a single procedure.

Polyposis of Colon

The dangers of malignant degeneration, hemorrhage and intussusception are such that children with diffuse polyposis are best treated by a partial or complete colectomy. The magnitude of the operation makes it too risky in the first few years of life. Carcinomatous change is unlikely at this time. Ideally, the surgery should be delayed until the child is six to 10 years of age.

Bronchiectasis

Most children with bronchiectasis respond well to medical therapy. Surgery is carried out in the pediatric group when conservative measures fail, and if the diseased tissue is reasonably well localized. Foreign bodies and bronchial anomalies rate high along with pneumonia, allergy and sinusitis as the etiologic factors in the bronchiectasis of childhood. Surgery, if necessary, can be performed at any age.

Pectus Excavatum

Mild cases of pectus excavatum do not need surgical correction. In severe instances there will be compression of the mediastinal viscera and esthetic considerations. Dorsal kyphosis is reversible if the condition is treated in childhood. Surgery should be delayed until the child is three to five years of age.

Patent Ductus Arteriosus

Although a number of children with a small patent ductus would live long, normal lives, the risk of surgery is less than the risk of possible complications if the condition remains untreated. When there is a bacterial endarteritis, cardiac failure or retarded development, the surgery becomes more imperative regardless of the child's age. Surgery is contraindicated when the ductus is compensating for another cardiac anomaly. Whenever possible, the operation should be performed between the ages of three and 10 years.

Coarctation of the Aorta

The over-all poor prognosis of untreated coarctation of the aorta makes surgical correction highly desirable. Except in those unusual instances of uncontrollable cardiac failure in infancy, the operation should be postponed until the aorta has developed sufficiently to assure adequate patency in adulthood. Surgery after the age of nine is recommended.

Tetralogy of Fallot

A high mortality and the unpredictable result make surgery for the tetralogy of Fallot in the first three years of life undesirable. Good results require continued adequate patency of the vascular anastomosis or valvulotomy as the child grows.

Cleft Lip

A cleft lip should be repaired as soon as possible, even within 48 hours after birth, if the general condition of the infant allows. If not, a three to six week interval may be allowed for satisfactory improvement. In double clefts of the lip, repair is often made somewhat later, as this procedure is of greater magnitude. Early repair of a cleft lip will facilitate feeding and will do much to relieve the anxiety and embarrassment of the

parents at the earliest possible time. Establishment of anatomic position will allow a more normal growth and development, with the best possible restoration of the lip and associated nasal deformity. Pressure of the repaired lip will narrow an associated cleft of the palate and allow the development of a more normal dental arch. Repair will help to control infections of the upper part of the respiratory tract, especially when there is an associated cleft of the palate.

Cleft Palate

The optimum age for repair of a cleft palate is generally 18 to 24 months, although a satisfactory repair may, in some instances, be carried out as early as nine months of age. The palate should be repaired before any definitive speech patterns have been formed; however, there must be adequate development to insure a proper surgical correction. Further, at this age, the child is a better anesthetic risk. Proper palate repair will provide velopharyngeal closure and assist in the separation of the oral and the nasal cavity. The repair will prevent foreign bodies from entering the nasal cavity; provide better hygiene of the mouth, nose and middle ear; allow the child to eat better; diminish upper respiratory tract and aural infections, thus preserving hearing; make the development of normal speech patterns more probable; improve ultimate dentition and facilitate any dental correction.

Syndactylism (Webbed Fingers)

Syndactylism is generally corrected at about five years of age, with surgery being carried out sooner if the deformity is severe and interfering markedly with the development or function of the fingers. Earlier surgery may be carried out if the joints do not coincide or the fingers are held in a compact group. If there is free movement of the fingers or a short skin web, it may well be satisfactory to allow some delay. The ultimate aim is to provide normal function of the fingers and to allow normal growth and development. If surgery is carried out at too early an age, even a minimal amount of scarring in a young infant may result in distortion of considerable degree in these early years. Further, at about five years of age, better delineation of structures and circulatory conditions allows a more satisfactory element of surgical safety.

Ptosis

Four or five years of age is generally the ideal time for correction of ptosis of the upper eyelid. At this age, when necessary, there will be adequate fascia lata for repair. The child will be a better anesthetic risk. Needless delay of correction may well result in poor vision or severe photophobia, from which the patient may never recover.

Prominent Ears

Prominent ears should be corrected at five or six years of age. It is extremely important to avoid ridicule and psychic trauma to the child in his early school years. Surgery at this time will not interfere with growth or development of the ears. A general anesthetic can be administered more satisfactorily and safely at this age.

Agenesis of Ears

Repair should be delayed in instances of agenesis of the ears until the child is five or six years of age, or even postponed until adolescence. The first stage, however, such as positioning of an ear segment, may be carried out at two or three years of age. The reconstructed ear does not keep pace with growth of the child and must be made of adult size at the outset. Normally, there is little further growth of the ear after eight or nine years of age. The best reconstruction of the ear will be obtained if surgery is delayed and one is not pressed into an earlier repair by the insistence of understandably anxious parents. Should the repair be carried out at too early an age, valuable tissue, essential for the best final results, may be needlessly sacrificed. It is believed that it is absolutely impractical to consider multiple total ear reconstructions during the growing years, but rather, construction of one definitive ear at the optimum time. Needless to say, absence of an ear is more noticeable in male children and reconstruction more important to them. Corrective surgery to improve hearing is generally carried out at two years of age in bilateral agenesis and at four to five years of age in unilateral agenesis.

Summary

While every patient should be given individual consideration, nevertheless, there may be an optimal age for the best result in elective pediatric surgery. An early surgical opinion and proper timing are stressed.

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To Catch a Thief

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There is a thief in our midst who all too frequently mingles unrecognized in our society and hence goes unapprehended. He is no respecter of race, creed, color or social position. So adroit is he in his ways that he often takes from us—painlessly, silently, but completely—our most cherished possession, our eyesight. His victims all too late discover they have passed the point of no return into the abysmal ink of blindness. His name is Glaucoma.

We as physicians can and must help. The responsibility for the diagnosis and management of ocular disease has by common consent long been left to the eye specialist. This system might be satisfactory if the more serious progressive ocular problems were promptly recognized and referred for care, but all too often they are not.[1] This is especially true of chronic glaucoma, in which adequate therapy depends upon early recognition. At least 20,000 persons, 15 per cent of the blind population in this country, are totally blind from glaucoma, and an additional 150,000 are blind in one eye.[2] Of greater importance are the estimated one million persons, approximately 2 per cent of persons over 40 years of age in the United States, who have glaucoma and do not know it.

For the sake of illustration, we can oversimplify glaucoma into acute and chronic types. The acute type is manifested by the violent, painful, sudden attack with nausea, vomiting and rapid loss of vision, a surgical emergency. The chronic type is characterized by the slow, painless, insidious but relentless loss of the peripheral field of vision, terminating in blindness. Regardless of type, in most cases there is the common sign of increased intraocular tension.

Reasonably accurate tension readings can be obtained with any one of a number of instruments. The development of the Berens-Tolman ocular hypertension indicator, however, has greatly facilitated the procedure for the estimation of intraocular tension by the general physician or the physician limited to specialties other than the eye. This small instrument costs only $12, is not delicate, and hence not as easily damaged as the more complicated tonometer, and gives a statistically proved, accurate indication of the intraocular tension.[3] The procedure is simple and takes only two to three minutes during the general physical examination. It can be as conveniently set up as the sphygmometer. How often do we order a routine roentgen examination of the chest to rule out tuberculosis or tumor; yet there are several hundred negative results for every new case detected. Serologic examinations for syphilis are routine for every hospital admission, and there are only about 30 positive results for every 1,000 samples examined. These 30 positive reactions include all the false positives and repeat responses to examinations performed in known cases. There were in Florida in 1955 only 151 new cases of syphilis per 100,000 patients, in contrast to 2,000 cases of glaucoma in every 100,000 persons over the age of 40.[4]

These data suggest that routine tonometry on persons over 40 may detect a higher percentage of physical abnormalities than some other procedures routine in the physical examination. Any physical examination lacking the determination of the blood pressure is believed to be grossly incomplete, but consider the difference in the end result by missing a case of hypertension and a case of glaucoma. Therapy instituted early in a patient with hypertension is less likely to modify the end results than early treatment in glaucoma. In the latter, a diagnosis a few months earlier may prevent severe irreversible disability.

Routine tonometry must become a part of the general physical examination before the one million undiagnosed cases of glaucoma can be detected—before the thief can be caught.

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Rapport in Medicine

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Rapport, probably, is as important a factor towards success with a patient as any attribute that may be brought to the practice of medicine. When a harmonious relationship exists between a physician and a patient, the patient has confidence in the physician and cooperates with him more easily. Sometimes rapport is secured easily, but usually it is attained after considerable effort. Consequently, the physician must be prepared with the tools necessary not only for its achievement but for its sustainment as well.

How is rapport secured? And how is it maintained? It is secured primarily by means of certain attributes which should be part of the physician. It is maintained with interviewing technics and by consideration and skill in the physical examination. It is strengthened when the physician demonstrates leadership during visits, special tests, therapy and convalescence and in dealing with the patient's family. At whatever point, the watchword is "do not offend."

The Physician

The importance of the attributes of a physician warrants dealing with them first.

Few physicians are physically attractive in the Hollywood sense; not all physicians are tall, dignified individuals, greying at the temples. Fortunately, there are positive personal features over which all physicians have control — cleanliness, neatness, simplicity of dress, a dignified carriage and a calm manner of speaking. These qualities are important because they instill confidence. Though desirable, a good physique is not essential to success in medical practice.

The personality of the physician counts and, if favorable, will have a favorable effect on his patients. If his face and speech will convey kindness, understanding and sympathy, the confidence engendered at the time of introduction to the patient will be nourished.

Wide interests and inquisitiveness about many aspects of life are helpful. Since much of medicine is scientific, and inquiry is the basis of scientific knowledge, it is to be expected that physicians will be of inquiring mind. Not all are as inquisitive as Ehrlich was, nor are all able to probe as well as he did; yet only through inquiry can the physician secure that general fund of knowledge which will permit him to deal with people of different interests.

During sickness anxiety takes its toll. It would be well, therefore, if a willingness and readiness of the physician to be helpful is easily discernible to the patient. If, in addition, the physician manifests a strong interest in his illness, the patient may be quieted and will be more easily started towards recovery.

The favorable reaction of his patients to his warmth will increase a physician's self confidence and help him develop what Sir William Osler often pointed out, namely, a high degree of equanimity. When a physician attains a state of calmness, he is not thrown off balance by little disturbances and only rarely by big ones. He is then infrequently incapable of carrying out his work and its responsibilities.

The Interview

The art of interviewing is common to most professions, but even the experienced interviewer who has studied interviewing technics finds he could expand his knowledge. Since historical information contributes largely to an exact diagnosis, the medical interview frequently has been designated as the most important part of the examination of a patient. Enough time for a thorough and satisfactory interview, therefore, must be allotted to every new patient.

The patient should be comfortable in a pleasant office setting. Expensive furniture is not necessary, for good taste is the determining factor. If the physician is not gifted in interior decorating, he should secure the advice of someone who is.

The physician should "set the stage" for the interview. He might begin with a statement on a timely subject of interest to anyone. Another good idea is to begin with something worn by the patient. Of course, it helps the physician to learn something about the patient beforehand. It would not be good to talk about Shakespeare to a boxer unless he is another Tunney, and it would not be wise to discuss a controversial subject with someone who has fixed ideas on the subject and might be disturbed by discussing it. Nevertheless, it is

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advisable for a short time to "talk about" some subject the patient understands before taking up "the difficulty." The physician's purpose in "setting the stage" is to put the patient at ease so that he will feel free to tell a complete story of his illness.

The physician should be an informal teacher. The patient may not understand the importance of an interview and why much time is sometimes necessary. He should be told how a physician conducts an examination and how information secured during a satisfactory interview can contribute to a diagnosis. Why complete notes are necessary should be explained. The patient should understand the legal as well as the medical implications of complete records. In fact, a patient is more apt to return to a physician if he knows that the physician possesses a complete record of his case; moreover, he will feel an inner satisfaction in knowing that his physician is thorough. Such a physician is less frequently sued. The careful education of a patient is a practical investment, but advisable mainly because it stimulates a better understanding between the physician and his patient.

A physician cannot afford mental pigeonholing. Patients smell out moral pigeonholing or prejudice of any kind. Still the physician should not accept all that is related as if he had blinkers. He should watch for chronologic gaps, inconsistencies and possible concealment of what may be important information. He should listen carefully and critically and observe the patient as he tells his story; how he carries himself, how he speaks, how he uses his hands. Much information may be secured from observation alone. During an interview the physician should be as observant as Sherlock Holmes.

Questions should be handled judiciously. During the interview the patient "has the floor," and the physician should say as little as possible. In order to keep him to the point, it may be necessary to direct the interview at some point. Unnecessary digression wastes time and, what is worse, often confuses the story. Questions are asked tactfully as well as sparingly. One does not ask "How much whisky do you drink?" or "How many abortions have you had?" It is better to substitute such words as miscarriages and beverage even to patients in whom abortions and whisky are commonplace.

Emotion or emotional overtone in the telling of a story is important. A widow may be unconsciously seeking sympathy, a young woman may be reacting to a broken engagement, a family man may have lost his job. On the other hand, the patient may be physically as well as emotionally ill. If emotion interferes with the telling of a coherent story, the physician should carefully help the patient return to "a position" more favorable to the telling of a coherent story. If emotional overtones becloud a patient's story, the physician must be considerate but especially careful of his interpretation.

The purpose of an interview is to secure all available historical facts concerning the illness of a patient. The skill in keeping the patient "to the point" without losing rapport is in the art of interviewing.

The Physical Examination

From the standpoint of maintaining the rapport achieved during an interview, the physical examination is not merely a series of physical maneuvers. The attitude of the physician and his skill are important. If rapport is retained, the patient is relaxed and cooperative, contributing to a more revealing examination.

The patient should be told how the physical examination will be made, in order to offset surprise or offense. A pleasant tone is helpful, and, in the case of children, a soothing tone may be employed. A sharp tongue or a brusque manner can destroy rapport as easily as rough handling. The presence of a near relative should be requested during the examination of a female patient if a nurse is not available, and unnecessary exposure should be avoided in the case of a male as well as a female patient. In examining the pelvis of a virgin, the rectal route should be selected unless it is inadequate. When skill tempered with consideration guides the physician in a physical examination, rapport is retained, and physical findings are easier to elicit.

Leadership

Leadership is important during the period of special tests, therapy and convalescence and in dealing with the family of the patient.

If facts secured from the interview and physical examination are not contributory to a diagnosis, or if confirmation is desirable, special tests are required. Why they are necessary, then, should be explained, and it should be clear that only tests which can be most revealing were chosen. The patient should feel assured that there will be no unnecessary medical costs and

should understand the basis on which he will be charged. It is regrettable to lose a patient after rapport has been established, and it is distressing when an outstanding bill strains a physician-patient relationship. Even if the physician has not mentioned the bill, the patient may hesitate to report for another appointment. With suitable leadership, the patient will keep appointments, tests will be made, and the results of good medicine will ensue.

Certain therapeutic procedures need detailed directions while others require little instruction. Some instruction, nevertheless, always, contributes. Directions should be clear, and possible untoward reactions should be pointed out. Medications should be judiciously chosen and dosage gauged with care. Even a small dose of phenolphthalein can be irritating. To a sensitive patient 5 grains of aspirin may produce ringing in the ears while to another 20 grains may be insufficient as a sedative. Patients appreciate physicians who treat with care, who explain prescriptions, and who suggest a telephone call if questions arise or if untoward phenomena develop. Regardless of the therapeutic regimen, however, the patient should feel that what is being done is helping him recover from his illness. This objective is also accomplished through leadership.

A convalescing patient should feel that his physician's concern about him is sustained. Proper supervision may shorten a period of convalescence, and often there is need for special care. Even if no care is required, a sincere telephone call works wonders. A leader is continually interested in those who depend on him.

The family of a patient is always involved in his illness, so that the physician should try to establish rapport with close relatives. Actually, he should seek out at least one that may be relied upon. Close relatives can be helpful medically as well as psychologically. A wife or mother may have to do some nursing, while another relative may be able to take over some of the responsibilities of the patient, thus relieving him of possible worries. If death is inevitable, it is good to consult first with the reliable member of the family. Such news always needs wise handling. It is better if preparations — psychologic, religious and economic — can be made. Regardless of the medical status of the patient, he benefits when his family cooperates with his physician. To secure such cooperation the physician again must exhibit leadership qualities.

Summary

Rapport is necessary to the success of a physician-patient relationship. It should be secured as early as possible and retained throughout the interview, physical examination, period of special testing and period of therapy, and also when one deals with the patient's family. With physician-patient rapport the facts necessary for a diagnosis are obtained more easily, and therapeutic measures are carried out more successfully. If such rapport deteriorates, the patient does not benefit from all the aspects of good medical care.

Jackson Memorial Hospital.

Scientific Papers, Exhibits and Films Requested for Association's Annual Meeting

The Scientific Work Committee of the Florida Medical Association has requested that members of the Association desiring to apply for places on the scientific program of the Eighty-Fourth Annual Meeting contact Dr. George T. Harrell Jr., Chairman of the Committee, College of Medicine, University of Florida, Gainesville.

The scientific program will be divided into three phases—papers, exhibits and films.

Members desiring to present papers on the program of the Scientific Assemblies should submit an abstract of about 50 words on the subject they plan to discuss. For places on the scientific exhibit program, a photograph or sketch of the exhibit together with a brief description of the subject should be submitted. As for films, a short description of the content is necessary. Films should not be more than 20 minutes in length.

Dr. Harrell has announced that the deadline for submitting applications is November 1. He and his Committee will meet in Gainesville on November 16 to select the papers to be presented and the exhibits and films to be shown.

Serving with Dr. Harrell on the Scientific Work Committee are Drs. Franz H. Stewart and Donald F. Marion, Miami; Dr. Richard Reeser Jr., St. Petersburg, and Dr. Gretchen V. Squires, Pensacola.

ABSTRACTS

Protein Bound Sulfhydryl and Disulfide Groups in Squamous-Cell Carcinoma of the Uterine Cervix. By Alvan G. Foraker, M.D., and William J. Wingo, Ph.D. Am. J. Obst. & Gynec. 71:1182-1188 (June) 1956.

To obtain additional information bearing on the problem of growth in the uterine cervix, protein-bound sulfhydryl and disulfide groups were studied in 27 cases of squamous cell carcinoma of the uterine cervix and three cases of intraepithelial carcinoma. These were compared with biopsies of non-neoplastic cervices. The results showed: (1) Sulfhydryl groups, related to various phases of cell metabolism, were found in endocervical glandular epithelium, and in all viable squamous cells, whether occurring in epithelium of the portiovaginalis or in intraepithelial carcinoma. Sulfhydryl groups were also found in regions of neoplastic and non-neoplastic keratinization. (2) Disulfide groups, related to cell keratinization, were found in keratinizing surface squamous cells, in epithelial pearls of squamous carcinoma, and in keratinizing neoplastic cells.

A Statewide Program for Hospitalization of the Indigent. By H. Phillip Hampton, M.D. J. A. M. A. 162:630-632 (Oct. 13) 1956.

Care of the poor is a measure of civilization, but indigency must be recognized as a disease, the end result of several causes—economic, sociologic, medical, and political. The judicious use of aid may relieve suffering and perhaps help to remove the cause of indigency, but indiscriminate welfare programs, especially politically inspired, will be insidiously destructive of initiative and create more dependency. The treatment of indigency must be specific; a panacea will lead only to addiction. The goal of successful therapy must be rehabilitation to independence.

With this generalization, Dr. Hampton outlines the specific program in Florida, where he is chairman of the State Advisory Council on Hospitalization Service for the Indigent. The provision of hospital care for the indigent in this state has been a responsibility of the individual county governments, but the unevenness of budgeting and frequent evasion of responsibility have made the county line, for some patients, a barrier to good medical care. Recent legislation has made it possible to initiate a program for hospitalizing the acutely ill indigent by creating a state and county matching fund out of which payments can be made directly to hospitals for the cost of caring for certified indigents. Further decisions will have to be made concerning outpatient care for the indigent and compensation to physicians for indigent medical care. The Florida Medical Association has authorized a foundation fund to promote graduate medical education in hospitals, provide outpatient care for the indigent, and encourage better medical care throughout the state.

Rehabilitation to independence must be the primary purpose of medical care in order to eradicate effectively the disease of indigence, Dr. Hampton concludes. Intelligent administration of indigent medical care programs by cooperative effort of the medical profession will provide opportunity for rewards far beyond the medical service rendered.

Study of Respiratory Liver Metabolism in Surgical Patients. By H. Clinton Davis, M.D., Irwin S. Morse, M.D., Edward Larson, Ph.D. and Mark Wynn, M.S. J. A. M. A. 162:561-563 (Oct. 6) 1956.

Liver succinoxidase, oxygen-quotient (QO_2) determinations were made on 10 patients undergoing surgery for gallbladder, colon, or pancreatic disease or peptic ulcer; four patients with obstructive jaundice had liver function studies in the course of their preoperative evaluation. Values suggested slight impairment of in vitro activity of the enzyme system in the presence of obstructive jaundice in comparison to an apparently normal liver. The concept of performing direct physiologic studies on human tissue is believed by these authors to be of possible value just as it has been in laboratory animals. They observe that the clinical physiologist could well fill some of the gaps in the understanding and assessment of altered metabolism.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

Medical Education in Florida



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Progress Report: University of Miami School of Medicine

HOMER F. MARSH, PH.D., DEAN

The School of Medicine begins its sixth year in September 1957. The five years since its initial opening in 1952 have been busy ones. There have been many rewarding accomplishments, and there have been a number of situations harrassing and embarrassing to the School's Administration and Faculty. Presumably, this is a necessary part of "growing-up" to be faced by any newly organized medical school although some of the situations are highly confusing of background and necessitate a dilution of effort and energies which could be better spent in other directions. The present status of the School has been achieved through adherence to certain basic principles and in the exercise of patience and a sense of humor.

A sketch of the status in 1952 will serve as a reference base for further comparisons. As the School opened, a faculty component of two full time anatomists, two full time biochemists, and a practicing psychiatrist who gave voluntarily of his time; a class of 28 students; the writer as Associate Dean; and eight cadavers; constituted the active and passive personnel. Instruction was started in remodeled quarters at the local Veterans Administration Hospital, and the County of Dade had agreed to the use of Jackson Memorial Hospital when and if it were needed for the clinical phases of instruction. The Dade County Medical Association had presented a resolution to the University attesting its interest in and desire to assist the new School. Contrariwise, a group of five "citizen-tax-payer watch-dogs of the State's Treasury" had instituted legal action to prevent the payment of state subsidy support to the School. This, then, was the picture in 1952.

Present Status

Despite its inauspicious and austere beginning, the School has grown in stature and scope of activity. Soon after the beginning of the fourth year of instruction, the Liaison Committee on Medical Education made recommendations which led to full accreditation of the School prior to graduation of its first class.

STUDENT BODY. Each year, an increasing number of students has been admitted to the beginning class. In September 1957, 75 Florida residents and five nonresidents are enrolled in the first year class. This number approaches the maximum number planned for the School, which is 76 to 84 per class. All students admitted to the first five classes were residents of Florida; indeed, in keeping with terms of the legislation governing the subsidy support, all had been residents of Florida for a minimum period of seven years prior to admission. That the state as a whole has been served in the student body is reflected in the origin of the students. Fifty of the state's 67 counties have been represented or are now represented by enrolled students.

The School now has 60 graduates. Although Florida's medical licensure laws do not require an internship as a prerequisite to licensure, all graduates have completed or are now engaged in internships. It bespeaks the acceptability of the instructional program that men and women who have completed the four year program have served or are now serving internships in hospitals such as the Philadelphia General, Washington University Medical Center, University of Texas Medical Center, University of Illinois Research Hospital, Grady Memorial of the Emory University Center, and the New York Hospital of the Cornell group.

The "proof of the pudding" will, of course, come to light as the graduates take their places in the communities of the state as practitioners, and about one half of the first graduates are now settling down in practices; the remaining one half is occupied in various graduate training programs in special fields of medicine and surgery.

FACULTY. The major number of faculty members of the preclinical departments are full time, salaried appointees and devote their entire time to the School's requirements. A few physicians, interested in one or another of the preclinical fields, are serving on the instructional staff as volunteers.

The heavy demands of administrative nature, organization of the teaching activities, development of research work, and the supervision of patient care, have necessitated the organization of the clinical departments around a core of full time faculty members. This core has been supplemented and complemented by a number of faculty members drawn from the practicing physicians of Dade County. From the initial group of four full time and one volunteer member in 1952, the faculty has expanded to about 100 full time and 485 volunteer members in the current academic year.

About 35 of the full time members are in the preclinical departments, and the remainder are in the clinical departments of medicine, surgery, pediatrics, obstetrics-gynecology, and psychiatry. It is worthy of note that about 20 of the full time men in the clinical fields are supported from extramural funds and devote a major portion of time to research activities.

In the relationships between the School and its teaching Hospital, the chairmen of the five major clinical departments, and chairmen of sections therein, also are chiefs of the corresponding hospital services, being responsible for the supervision of the care of staff patients of the Hospital and its clinics.

Organization of the clinical segment of the faculty has not escaped criticism of a few members of organized medicine who believe the salaried faculty violates the code of ethics and principles of organized medicine. Although this is not the place, nor is there adequate space in which to present an exhaustive picture of the situation, suffice it to say care has been taken to avoid any implication of the School's practicing medicine as a corporation. Full time faculty members who are licensed as physicians are permitted to see private patients in consultation or for ultimate care PROVIDED such patients are referred to them by another licensed and practicing physician. There is a dollar limit placed on the extent of such practice, and neither the School nor Hospital requires the faculty member



Present Preclinical Sciences Building in Coral Gables. VA Hospital appears in background.



Model of Medical Education and Research Building. Construction to begin in October 1957.

to turn over to either of these institutions any part of his earnings from this or other sources.

INSTRUCTIONAL FACETS. The primary *raison d'etre* for this or any undergraduate medical school is to offer a solid educational experience in the inter-related basic medical sciences and the clinical applications thereof. Although different technics are used for accomplishment of this objective, our own curriculum is organized in such a manner as to provide for three basic thoughts. (1) There is an opportunity to guide the students through an experience in the basic sciences as individual disciplines, yet (2) integrating between the various basic sciences to show their interrelationships as parts of medicine as a whole and, (3) correlating between the basic sciences and the clinical areas to show the dependency of the latter on the former.

Time does not permit a detailed explanation as to the manner in which these ideas are effective, but it is sufficient to say that the manner lies somewhere between the commonly applied "vertical" plan of building on the basic sciences as separate disciplines and entities, and the newer-developed "horizontal" plans which attempt to bring all aspects of a four year curriculum into one completely integrated whole.

Two or three interesting and unusual aspects of the instructional work may be presented herein.

In an effort to make an opportunity for students' appreciation of the general practice of medicine, a program is operating in the fourth year curriculum. In this year, students spend almost 100 per cent of their time in the clinics under supervision of the faculty. The general medical clinic is staffed by a full time internist, medical resident house staff, general practitioners, and medical students. Students who are assigned to this clinic work alongside the general practitioners as they see the patients and have the opportunity to observe them in their approach and relationships with patients. In the event an extraordinary situation presents itself, the internist is at hand for assistance. At the end of the clinic session, a group discussion is held between all staff of the clinic, and selected cases are reviewed. It is during such sessions that the students and general men may profit by the observations of the internist. The student has a chance to benefit from the activities and contact with the general men, and the general practitioner has a chance to benefit from a continuing postgraduate experience. At the present time, about 50 general men are working in the medical clinics, and it is planned this type of participation will be extended to other areas of medicine for the benefit of the general men.

The geographic area holds attraction to many elder citizens. Many of these men and women make positive contributions to the community, yet many have problems which may be nonmedical in basic origin and need help in resolving their difficulties which may take on a medical aspect. Two years ago a gerontology clinic was organized as an experimental clinic. This is spoken of as the "comprehensive medical clinic" or "total-push" program. Professional personnel includes internists, psychiatrists, clinical psychologists, social service workers, and welfare workers as a tightly knit team which attempts to evaluate all facets of a patient's complaint. After a patient has been seen by the individuals of the team, a con-



Aerial view of Jackson Memorial Hospital, clinical teaching facility.



Small group conference teaching, Department of Obstetrics-Gynecology.

ference is held in an attempt to work out relief for the patient. His problem may be simple of solution, needing, perhaps, only guidance into broader social contacts, or some assistance from the Welfare Department. If the problem is essentially medical, the patient will be referred to a specific clinic for remedial measures. Under any circumstances, the clinic functions as a good area for emphasizing the comprehensive picture of man and the various interrelationships which may have an impact on his well-being. It is worthy of note the latest faculty addition to this clinic is a physician who, although 80 years old, still is quite capable of appreciating the problems of the aged and interested in getting down to basic issues involved therein. The clinic's activity has grown rapidly and is exciting comment nationally.

Research Activity. No modern medical school can expect to build its reputation on the quality of its instructional programs alone. Not only is the faculty expected to offer a sound educational opportunity, but it is expected to further medical knowledge and skill through research. Although it has been quite busy in initial organization, the faculty has expanded its research interests and activities until, in the current year, almost $1,000,000 in research activity is supported by various independent and governmental agencies. As about 100 specific projects are included in the over-all program, these cannot be listed herewith, yet a few may be touched upon in brief.

To a Floridian, perhaps one of the most startling subjects for a research project is "smog," yet the U. S. Public Health Service succeeded in interesting our Department of Pharmacology in this very important problem. Supported to the amount of almost $50,000 annually, this project has a basic objective of studying the toxic constituents of smog and attempting to learn more of the mechanisms which lead to the formation of this dangerous pollutant in air. The same department is deeply involved in testing numerous compounds used in industry for their potential toxigenicity and, particularly, their carcinogenic properties. During the summer just past, a rather comprehensive undertaking at the request of the U. S. Air Force was outlined and put into operation. This concerns the possible detrimental effects of exposure to radar radiation of high frequency. This program will involve a number of the departments and will attempt to clarify many mystifying observations involving the effect of radar exposure on the human as a whole and on isolated tissues.

As a result of a collaborative effort between the Department of Bacteriology and the Variety



Students' first introduction:
Anatomy, with Dr. George H. Paff.

Childrens Hospital, a virus diagnostic laboratory has been in operation for its second year. The laboratory, in so far as can be learned, is the only comprehensive facility for service and research in Florida for virus studies. Studies on the antigenic structure of viruses and basic features of immunity in the virus diseases are being made.

Advances in the surgery of the heart have demanded better means of carrying the patient along during such surgery. The Department of Surgery has been quite active in improving heart-lung bypass equipment to permit a more convenient medium in which the cardiac surgeon can perform his work. A rather complete experimental animal surgery in the Department of Surgery provides facilities for expanding the skills and knowledge in the field of surgery.

Three basic areas of activity have commanded the attention of the Department of Medicine. An extensive, nationwide approach to the chemotherapy of cancer is being directed from this Department. This work involves the chemical synthesis of new compounds, their screening in animals for chemotherapeutic effect, and final testing in humans of any which show promise. Parts of this work are being carried on in about half-a-dozen medical schools in the United States, and in several hospitals scattered throughout the nation. Cardiopulmonary laboratories supported jointly by the Miami Heart Institute and the School of Medicine provide excellent and complete facilities for studies of physiologic background involving various cardiac conditions. A third broad area of activity is that concerning studies on connective tissue. These are basic



Pathology Laboratory.

studies designed to throw light on the role of connective tissue in aging and in cardiac disease. The work was recently recognized by a prize from the Ciba International which, annually, reviews the tremendous amount of work done in the aging processes by investigators throughout the entire world.

The School is pleased that the magnitude and quality of research being carried on has improved constantly. That this work is done in rather meager quarters attests to the broad and consecrated interests of the faculty.

Physical Facilities. The provision of adequate physical plant in which the School's work may be carried on has hardly kept pace with demands. The preclinical science departments still are housed in the remodeled building at the Veterans Administration Hospital in Coral Gables, while the clinical departments carry out their work in the Jackson Memorial Hospital. Only recently, provisions were made to relieve the rather acute shortage of space for research activity by two moves. A sizable building located adjacent to the Hospital was purchased by the University and remodeled to house certain basic research laboratories used essentially by the Departments of Medicine and Surgery. In October 1957, construction is scheduled to begin on a new medical research building which will be of eight stories and about 100,000 square feet of floor space. This building has been financed in part by a grant from the U. S. Public Health Service and in part by the University. Its completion will do much to relieve the problem of housing research programs.

The next major requirement in the School's development is that of providing a more adequate educational building, and although plans have been roughly laid out to include a $3,000,000 structure, funds have not yet been accumulated. The educational building is planned to become a physical extension of the research building and will have its activities integrated on a departmental basis with the floor layout of the research building.

The School is fortunate in having the facilities of Jackson Memorial Hospital at its disposal for clinical instruction. This hospital, of 950 bed size, is in the process of expansion as provided by a $6,000,000 bond issue approved by the freeholders of the County last November. When this expansion and improvement program is completed, it will be difficult if not impossible to find a better clinical teaching facility in the southeastern states.

The picture of the School as it is today reflects a major beginning toward an outstanding and complete medical education and medical service center in Dade County. In the immediate future, prospects are bright for some important additions to the over-all situation involving the School and its teaching hospital. Plots of land have been assigned to two groups on which it is planned to build two private hospitals adjacent to the teaching hospital. A third group is in the discussion stage of coming to an affiliation with the School and removing present facilities to the grounds of Jackson Memorial Hospital for improved patient care and teaching programs in the area of children's diseases.

Despite certain temporary needs, the School's Administration and Faculty believes the state's investment through subsidy support has been justified and that all areas of the state are certain to benefit from the investment.



University of Florida College of Medicine

GEORGE T. HARRELL JR., M.D., DEAN

On Sept. 8, 1956, the first class of 47 medical students was enrolled in the new College of Medicine of the University of Florida at Gainesville. The basic philosophy on which the program has been planned was described in the September 1954 issue of the Journal of the Florida Medical Association. A more complete discussion of the role of the University in medicine was presented later to the Council on Medical Education and Licensure of the American Medical Association and published in the Journal of the American Medical Association, June 23, 1956. The faculty is deeply grateful to the Florida Medical Association for its advice and help in our planning and for its solid support during these formative years.

Students

The first class, which will graduate in 1960, was selected from 280 applicants. In all, 124 prospects were interviewed personally by the faculty selection committee. The ratio of Florida residents to nonresidents among the applicants was 3:2. Ten women applied, and three were accepted. The 44 Florida residents came from 20 counties, from Escambia to Dade; the maximum number, from Duval, constituted 15 per cent of the class. One student each came from Maryland, New York and Wisconsin. At the time of admission, 18 students (38 per cent) were married, and others have subsequently taken the step. Only two students had not received a Bachelor's degree at the time of entrance; five had advanced degrees in bacteriology, psychology, chemistry, or agriculture. The scores achieved on the Medical College Admission Test, which is administered nationally to all prospective students, places the class average in the upper 50 percentile of the entire country.

The students entered from 13 different colleges out of the state and three in Florida; slightly less than half of the students (23) entered from other colleges in the University of Florida. Three students received state scholarships in 1956, and an additional one was awarded to a second year student in 1957.

The 50 members of the second class (1961), which will enter this month, were selected from 332 applicants. The 43 Florida residents come from 19 counties, and seven nonresidents from Georgia, Illinois, Connecticut, Massachusetts and New York. The students enter from 19 colleges and universities throughout the country. Four received state scholarships.

The same size classes will be accepted for the fall of 1958 and 1959; thereafter, the classes may be enlarged to 64 if the number of high quality applicants increases.

Faculty

An exceptionally well qualified, young and enthusiastic faculty has been recruited for the basic science departments. Chosen on the basis of teaching ability and research potential, individual members were selected to bring together widely varied backgrounds and interests. A determined effort was made to obtain men and women who had a liberal arts background and who had attended small colleges before they had undertaken professional training in a large university. Three of the department heads have been abroad since joining our faculty to lecture in medical schools in Europe and South America or to give scientific papers at international meetings. Others had received part of their training abroad before coming to Gainesville.

The faculty for the third and fourth years of clinical teaching is now being selected. The head of the Department of Medicine is in residence and other members will be arriving in the fall. The Professors of Surgery, Psychiatry, Obstetrics, Pediatrics and Radiology will be appointed during this school year.

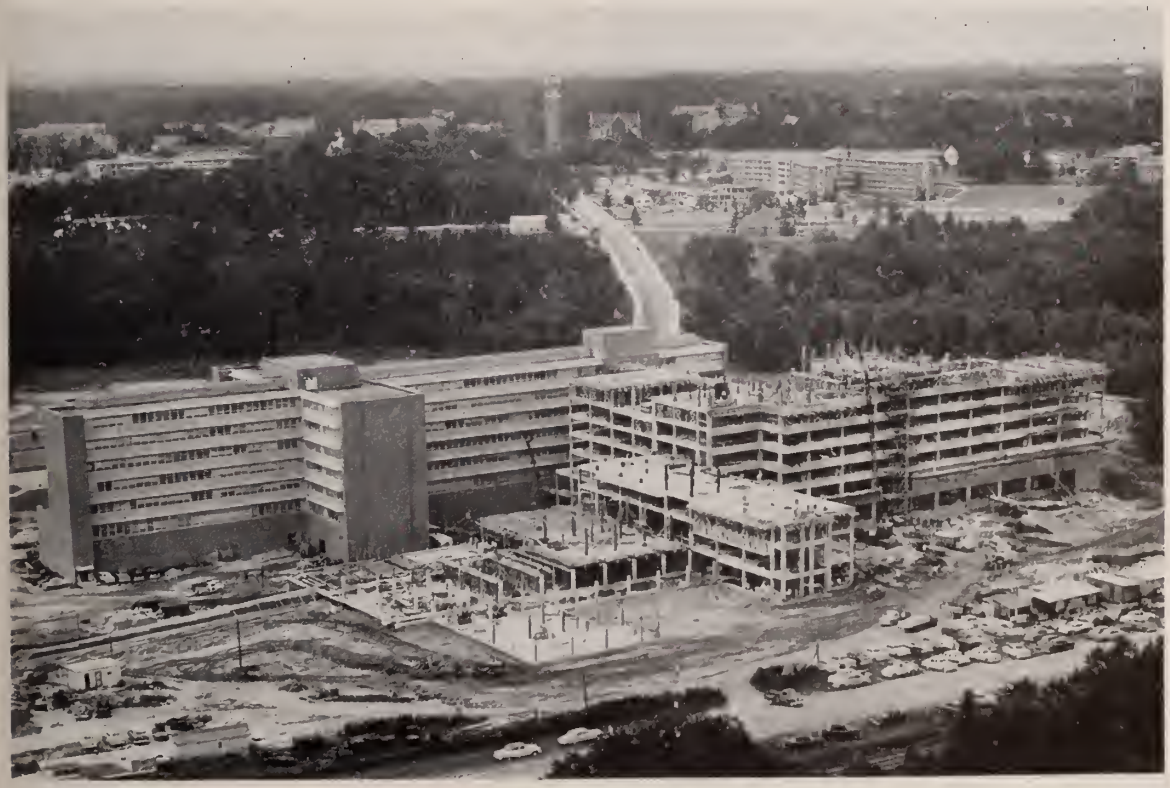
New department heads are appointed approximately one year in advance of the time their teaching duties begin. This "lead time" is extremely important and offers the chairmen an opportunity to search widely for staff, examine teaching methods in use elsewhere and develop a curriculum fitted for our needs. This amount of time is required also to select equipment carefully and order supplies, write syllabi and laboratory outlines, plan research programs and tend to a multitude of other details before student teaching begins and the patient load develops.

Physical Plant

The new school was located on the University campus so that it might rely on all the resources of a large State University and participate in the other varied educational activities under way. The land chosen for the site is situated toward the periphery of the heavily built up area of the present main campus. In this manner a satellite operation can be developed with sufficient room to become a cohesive unit as new programs are activated in the Health Center. The site is in close proximity to the rest of the campus for students' convenience, but on a highway for the ready transportation of future patients. In this fashion the problems of traffic, parking, growth, and addition of other units—such as pharmacy, dentistry, and research—could be anticipated and preliminary planning done now.

The Medical Sciences Building has been designed with a basic science wing toward the west and a wing for the clinical departments toward the east. In the cross wing are certain expensive large facilities which will be shared. The basic science and clinical departments placed on a given floor were selected so that they might have a common interest in teaching, research, or both. In this fashion it is hoped that departmental barriers will be kept to a minimum and that the student will tend to think of both clinical and preclinical areas as different facets of medicine as a whole. This design results in two vertical axes for movement of people and supplies: one at the center of the building for the medical school; and a second off the main lobby to the east for nursing and other fields related to clinical medicine.

The Teaching Hospital connects with each of the seven floors of the Medical Sciences Building; two floors extend above. Functions in the hospital have been related floor by floor with the present building. For example, the ground floor is planned for horizontal movement of supplies which would be carried in carts or handtrucks. At this level are found the receiving dock, storage spaces, morgue, shops, post office and locker rooms for personnel. The first floor is planned for horizontal movement of people—students, patients, visitors and staff. On the second floor, the Department of Anatomy is placed with the surgical specialties of urology, orthopedics and neurosurgery,



The J. Hillis Miller Health Center on the campus of the University of Florida at Gainesville. The Medical Sciences Building, at the left foreground, which houses the College of Medicine and College of Nursing, was dedicated Oct. 13, 1956. The 400 bed Teaching Hospital and Clinics, in the right foreground, is scheduled for occupancy in October 1958. Dormitories and classrooms for other parts of the University are shown in the background.

which can help in the teaching of anatomy. The workshop for surgeons is the operating room, and the clinical visualization of anatomic structures is done with x-rays; so these two functions are found on the second floor in the Teaching Hospital and clinics. This horizontal functional relationship has been carried out as far as possible throughout the entire physical plant.

The main vertical axis for the hospital opens off the corridor which connects the main lobbies of the hospital and Medical Sciences Building. Staff, visitors, and students can reach any floor whether they enter from the campus or highway. A secondary axis for ambulatory patients who will be housed in the new type ambulant floor and seen in the clinics is provided. Supplies and food will move by dumb waiters which open into rooms at the nursing station on each floor. Papers, records, and small items can be sent through an automatic pneumatic tube system. A Health Center dial phone system and an intercom system to each patient room on each floor complete the communication network.



One of the individual study cubicles assigned to each medical student. Called a "thinking office," it emphasizes the most important part of a physician's work and thus preparation for medical practice. In many other ways, the design of the Medical Sciences Building demonstrates the student-centered program of the College of Medicine.

Teaching facilities have been planned with the greatest amount of flexibility possible. A study cubicle has been designed so that the student may start on his first day in medical school the pattern of thinking he will follow for the remainder of his professional life. For the first two years the study cubicles or "thinking offices" are placed on the first floor of the Medical Sciences Building; for the third and fourth years they will be located on the same floor of the Teaching Hospital equally distant from the library.

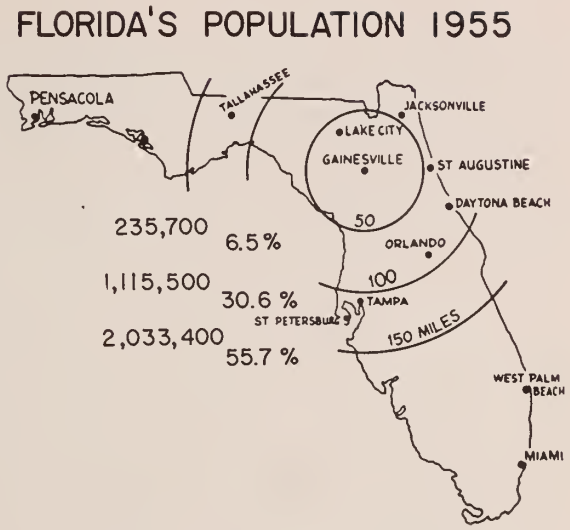
All classrooms and laboratories on all floors have been sized for student groups of 16. Seminar or small classrooms for a single group also serve as departmental libraries and are found in each wing. Intermediate size classrooms for two to three student groups (35 to 50 students) are found at the clinical end of the building so that they may be used by the College of Nursing and by allied health professions as well as the clinical departments. Lecture rooms seat three to four student groups (50 to 70 students). The student laboratories have been designed as multipurpose facilities. Four student groups (64 students) may be taught at one time, or each of the laboratories may be divided by movable partitions into two, three or four units. In all teaching laboratories each student has his own place in the center. Large basic pieces of equipment which are shared by a group are found at the ends of the laboratories against blank walls. Special instruments or demonstrations for each group are found at the sides under the windows on unassigned counters, each of which contains its own storage space. Opening off each side of the main teaching laboratories are preparation rooms for the departments housed in that wing. In this fashion maximum use of the laboratories can be achieved for more than a single course. A general type "sit-down" laboratory has been placed on the even-numbered floors while special "stand-up" type facilities are found on odd-numbered floors. Lecture rooms primarily designed for projection are on even-numbered floors, while those intended chiefly for demonstration are on odd-numbered floors. By this arrangement a class need only walk up or down one floor to use a different type of facility.

On the ground floor, animal quarters have been placed at the west end and library stacks at the east end of the building so that these two

facilities can expand without any disruption of the functional arrangement as new units are added to the Health Center.

The research laboratories have been designed with a four and one-half foot architectural module. This module permits the use of interchangeable bench units and allows six inches for pipe space with each unit. Two modules are used for graduate student, house officer, fellow, or junior faculty member office-laboratory combinations. Three modules are used for two to three house officers working together or for a junior faculty member and technician. Four modules constitute a full-sized research laboratory for a specific project with space for technicians, students, or research assistants. When two modules are added at one side, it is possible to have open into the laboratory a special instrument room which can be adapted to optical recording, tissue culture, and so forth and a small office for a senior faculty member. This project type laboratory has proved to be extremely efficient in the use of space and has attracted a great deal of attention because of its flexibility.

The 535 seat auditorium has been planned for public functions. A separate stairway opens off the main lobby of the Medical Sciences Building so that the use of this facility will not interrupt any activities in the medical school. The acoustics have proved to be almost perfect, so that the room is in great demand for chamber music concerts, various scientific and lay meetings



The location of the J. Hillis Miller Health Center in relation to the state, county and university campus. Over two million people, more than 50 per cent of the population of Florida, live within 125 air miles of Gainesville or three hours' driving time. On the basis of experience in other Southern states of comparable size, the majority of patients will be referred from the area within the concentric circles.



A multipurpose teaching laboratory equipped for the ultimate size medical class of 64 students. Lecture rooms, classrooms, and laboratories on each floor are designed for student groups of 16 or multiples of this student module. In the design of the physical plant every possible effort has been made to achieve the greatest amount of flexibility so that the curriculum may be changed from year to year and the teaching space used for many purposes.

by groups on and off campus—even the football coaches' "clinic." We have encouraged its use particularly for cultural purposes, to emphasize to the future physician that he must be a part of the community in which he practices.

From every part of the building, except lecture rooms and the auditorium, the student can look out at trees and green grass. This emphasis on intangible values and subtle influences has been intentionally planned in the building. The architectural design has been kept open to resemble the Florida type of indoor-outdoor living. Bright cheerful colors have been selected for floors and walls, and the general atmosphere has been kept as informal as possible consistent with a professional atmosphere.

A large number of visitors—medical educators, architects, practicing physicians from other states, as well as citizens of Florida—have been coming to see the building. The number of visitors and the detailed inquiries have been sufficiently great that one member of the nonacademic staff has been assigned to serve as a guide as needed. Educators and physicians from South and Central America, Australia, Canada, England, Germany, Sweden, Israel and other parts of the world have visited during the past year. We are particularly pleased that the general public is proud of its new medical school. It is a source of professional gratification that our architectural plans have been borrowed by new schools now in the stage of development as well as by established schools which are adding new buildings.

Equipment

The laboratory furniture for the major teaching areas and the research laboratories for the basic science departments has been installed. Insofar as possible, equipment has been selected which will simulate that in use in hospital laboratories or in the physician's own office. For example, a new type of portable, direct writing recorder has been designed and built especially for our Physiology-Pharmacology teaching laboratory. The data are recorded on paper strips which resemble the clinical ECG and EEG records which a physician obtains on his patients.

Specialized pieces of equipment for research —such as an ultracentrifuge, electrophoresis apparatus, radioisotope counters, phase microscopes and micromanipulator with miniature electrodes as small as one twenty-five thousandth of an inch —have been installed and are operating. On order and scheduled for delivery during the fall are the special fluoroscope and equipment for cardiacatheterization studies, respiratory physiology laboratory and an electron microscope.

We are indeed grateful to voluntary agencies in the state, such as the Florida and Volusia County Heart Associations, the American Cancer Society, the Damon Runyon Fund and many others which have given us sizable grants for the purchase of this equipment.

Curriculum

Because we are a new school on an established University campus, we are working with faculty and administrative groups from other parts of the University in studying means to improve the preprofessional preparation of students. Members of the medical faculty are serving as preprofessional counselors, and in return a biologist, political scientist and humanist are serving on the Medical Selection (Admissions) Committee. Every effort is being made to recruit students with a broad liberal arts background in addition to the minimum scientific requirements. With this preparation medical students can be treated as mature graduate students, and we can move more quickly toward our primary educational goal—the training of family physicians for practice in the small cities of Florida.

The curriculum has been arranged with free time regularly scheduled for all students, so that they may feel free to explore more intensively stimulating aspects of their studies which have already been presented in the classroom or laboratory, pursue independent research, or elect studies in other areas of the University. Our teaching is directed toward understanding concepts, principles and methods rather than toward an accumulation of facts.

Although the primary emphasis is on training for the M.D. degree, students interested in medical teaching and research may elect to work toward a Ph.D. in Medical Sciences. A graduate curriculum has been approved for broad training in all the basic sciences with a major field of concentration in Anatomy, Biochemistry, Microbiology, or Physiology. We will require that graduate students elect a minor field outside of the College of Medicine. Four students are already enrolled through the Graduate School and are in residence working at the College of Medicine toward this degree. As top-flight students apply,

this program gradually can be expanded to 40 or 50 students.

The College of Nursing has also completed its first year of teaching. During the past year, medical students regularly demonstrated dissections in anatomy to nursing students. Other joint teaching exercises are planned in subsequent years.

An internship and residency program has been planned for the Teaching Hospital after it is open.

Postgraduate Program

In June, the Twenty-Fifth Annual Graduate Short Course in Medicine sponsored by the Florida Medical Association was held in the Medical Sciences Building at Gainesville. The historical development of postgraduate medical education in Florida is described elsewhere in this issue. Organized postgraduate courses, in conjunction with the Florida Medical Association and the State Board of Health, are planned for the campus and may be extended to other parts of the state. Dr. William C. Thomas Jr., formerly a practicing internist in Gainesville, has been appointed to the full time faculty as Assistant Professor of Medicine and as Director of Postgraduate Education. His plans for continuing education are outlined on page 264.

Doctors may attend any teaching exercises at the school on an informal basis at any time and are welcome to use the library and other special facilities.

Research

Research is an integral part of good medical education. All of the departments in operation have active research programs under way. In view of the current interest in Nuclear Science in the state, it is of interest that all departments have persons trained in the necessary technics and are using radioisotopes in their experiments.

Research ranges in type from a fundamental basic study involving the kinetics of single enzyme molecules and the emission of quanta of light to problems that are immediately applicable to patient care such as the mechanics of respiration. The latter study is being conducted under a contract with the Department of Defense. Grants totaling approximately half a million dollars for support of teaching and research projects have already been received from the National Institutes of Health and other governmental agencies, voluntary health agencies, industry and private sources.

We have been extremely gratified that more than a fourth of the first class has requested permission to remain in residence during the summer to work in various research laboratories. We are especially grateful to the Florida and Volusia County Heart Associations for funds which have permitted us to support student research fellowships in addition to the six awarded by the National Institutes of Health.

Needs

Our greatest need is for scholarships and loan funds. Most University funds for this purpose are earmarked for other fields and are not available to medical students. The financial problem of a medical education has become increasingly pressing since the program of government support under the G. I. Bill is running out. The state scholarships are of great help, but are limited in number. With increasing inflation and with the trend toward earlier marriage in all college students, more scholarships are urgently needed.

We are indeed grateful to physicians in Florida who have made individual gifts for use as short term loans. We have estimated on the basis of present requests that a Revolving Student Loan Fund of $50,000 could be used immediately.

The students have been most appreciative of the radio-"hifi" record player–television set for the student lounge which has been bought with a donation from a physician in the state.

Future

The legislature has appropriated $1,451,000 to construct a building for the College of Pharmacy. This new wing will be built at the west end of the Medical Sciences Building so that the present basic facilities such as Library, Animal Quarters, and Sterile Central Supply already in operation can be utilized fully. Facilities have already been planned and are being built in the Teaching Hospital for use of the College of Pharmacy in its teaching program. It will be possible to give instruction in Hospital Pharmacy and to expand the program of research and training for careers in the pharmaceutical industry.

Enrollment in the College of Nursing has far exceeded expectations. It is most gratifying that the advanced curriculum has been so widely recognized. Students in the College of Nursing have come from as far as Vancouver, British Columbia. Expanded physical facilities for the College of Nursing are being built in the Teaching Hospital

and will be ready by the time the junior class goes on the wards.

An intensive study has been under way for two years to determine the best method for training students in other programs than medicine and nursing who plan to work in the health fields. When in full operation, this unique program of coordination of education and practical training could teach 500 to 600 students in physical and occupational therapy, x-ray and medical technology, clinical psychology, all phases of rehabilitation, hospital administration and many other fields. This program has been tentatively called a College of Health Related Arts. The physical facilities for training these associated health professions in the Teaching Hospital are being constructed in the rehabilitation area. Through the assistance of the Florida Development Commission, Wolverton Act Funds have been obtained from Mississippi and South Carolina to permit the completion and equipment of the rehabilitation area. Our Teaching Hospital is one of the few built since the war which has not received Hill-Burton construction funds. The limited amounts available to Florida have been used in community hospitals.

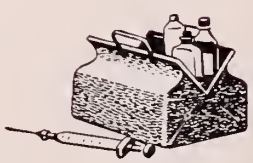
The forward-looking program sponsored by the Florida Medical Association for hospitalization of indigent patients should prove invaluable in our teaching program. Our hospital administrator is planning procedures and assembling a staff to open the Teaching Hospital now under construction and scheduled for completion in the fall of 1958. Patients will be referred to the staff by the family physician, except in the case of emergencies and accidents which will be taken care of as the need arises. As the name implies, all patients will be used for teaching.

Plans have been drawn and construction should start this fall on 104 apartment units for married students and house officers on the site to the east of the Teaching Hospital. Recreational facilities for the use of medical and nursing students, house officers and staff are planned for shaded areas adjacent to our site on the north and east.

The legislature has designated the University of Florida at Gainesville as the site of a College of Dentistry. This College could be incorporated into the Health Center. No immediate plans have been made for the development of this school.

As the University continues to grow, the Health Center with its key unit, the College of Medicine, will be flanked by other units of the University related to its program. Women's housing is now approaching us from the northeast, men's housing from the northwest, and instructional areas, including the Nuclear Science building which is part of the larger development of a Science and Technology Center, from the north.

It is our goal to make the College of Medicine and its associated units in the Health Center an extension of the strong right arm of the family physicians in the state and an institution of which the profession and people can be proud.



History and Development of Postgraduate Medical Education in Florida*

Approximately 26 years ago, Dr. Turner Z. Cason conceived the idea of having a six week midwinter seminar on medicine at Gainesville, Florida. At that time the thought was to present only didactic lectures. A general outline was presented to Dr. J. J. Tigert, President of the University of Florida, who was most enthusiastic and made every effort to begin such a course. It was planned that the first half of each week was to be devoted to medicine and the second half to surgery, thereby permitting the physicians in attendance who were not general practitioners or who did not wish to receive lectures in both surgery and medicine to spend the remaining days of each week seeing Florida and having a vacation. It was planned that English-speaking physicians from Central and South America would be invited, and Dr. Tigert offered to send the Professor of the Institute of Inter-American Affairs to invite these physicians and to explain the proposed plan and the purpose. There was no way by which the University of Florida could finance such a propect, and only $2,000 could be guaranteed. The estimated total cost was a minimum of $5,000. Beginning a project of this kind, one could not be assured of the attendance or the fees obtained from tuition; therefore, the idea was abandoned.

Up to that time, no serious thought had been given in recent years to the establishment of a medical college in the State of Florida. The efforts by the Florida Medical Association and the University of Florida to present graduate medical education to the physicians of Florida stimulated the thinking which led to planning for a medical college as a part of the University system. The reception of this thinking by the physicians of Florida aided in advancing the planning.

The following year, 1932, Dr. Gerry R. Holden, President of the Florida Medical Association, appointed Dr. Cason chairman of the Committee on Medical Postgraduate Course. The other members of this Committee were Dr. George C. Tillman of Gainesville and Dr. Thomas H. Bates of Lake City. At the first meeting of the Committee it was decided to begin the graduate work by holding a short course designed for the general practitioner, lasting from Monday morning to Saturday noon. At a conference with Dr. Tigert, it was the concerted opinion that this program should be placed under the General Extension Division of the University, of which Dr. Bert C. Riley was the head. The Division materially assisted by printing the programs, arranged for the meeting place at the University, and many other details.

The first course was held June 19-24, 1933, on the campus of the University. The first two years, an attempt was made to present to the general practitioners as many phases of general medicine as was possible. The Committee carefully analyzed the results and began to eliminate subjects gradually, concentrating on medicine, pediatrics, surgery, gynecology and obstetrics. This plan still left open five lectures, the subject of which has varied from year to year; among the subjects chosen have been diseases of the chest, psychiatry and plastic surgery.



Turner Z. Cason, M.D.

*Abstracted from a History of Postgraduate Medical Education in Florida, to be published by the University of Florida.

During the three years the course was held in Gainesville, it was most successful, and the University as far as possible cooperated. Many distinguished men, among them Dr. W. Wayne Babcock, Dr. Chevalier Jackson and Dr. Wilburt C. Davison, came down as instructors. These men were the forerunners of many eminent physicians who lectured at the short course in the years that followed.

Certain special regulations were established early. The time of the short course has always been the last full week in June. It was found that it was most difficult to get faculty members at any other time. At that time, physicians in teaching institutions were not so accustomed to making trips for this type of graduate program as they are now. Also, it was apparently the easiest time of the year for Florida physicians to attend. After the first two years, the Committee decided that those selected to lecture at these short courses must be out-of-state physicians. This was a regulation designed to prevent any criticism of the Committee for apparently promoting a private physician. The Committee also established a precedent to which it has rigidly adhered — never to ask a lecturer to return more than once in a successive year. This regulation has met with the satisfaction of those in attendance, and the lecturers themselves have expressed approval of such a ruling.

After three years, the University was so cramped for space that the Committee thought it should undertake holding the short course in some other city. The next two years it was held in Orlando, and the following two in Daytona Beach. Because of the heat and land breezes in Daytona in 1939, the attendance was poor, and at the insistence of the physicians who had attended regularly, the Committee decided to transfer the course given the sixth year to the air-conditioned Hotel George Washington in Jacksonville.

Because of a conflict in ideas between the Committee on Medical Postgraduate Course of the Florida Medical Association and Dean Riley of the General Extension Division, all relations with the University of Florida were severed during the year 1938-1939. This step was taken by mutual agreement. In 1939, at the solicitation of the Committee, the Florida State Board of Health became a co-sponsor. Since that time, the State Health Officer or his representative has sat in on all Committee meetings, rendering valuable assistance. The Board of Health has materially aided the program both in an advisory capacity and financially.

Beginning in June of 1940 and each year since then until June 1957, the short course has been held in Jacksonville. Each year for a number of years, those in attendance were polled as to the continuation of holding this course in Jacksonville. Each time the vote was almost unanimous in favor of holding it there. Several times a poll of the entire Florida Medical Association was attempted with similar results. In 1946, the question of holding it in different cities each year was seriously discussed by the Committee. The personnel of the Committee represented every section of the state, and after deliberation the members were unanimous in their opinion that it should remain in Jacksonville and in an air-conditioned hotel.

In 1942, a conference was held by the Chairman of the Committee and Dr. Tigert, at which time an invitation was again extended to the Committee to carry on the graduate medical course under the auspices of the University of Florida. It was proposed that a Department of Medicine of the Graduate School of the University be established and a director appointed. Dr. Tigert requested Dr. Cason to draw up specific recommendations for presentation to the Board of Control at its next regular meeting. This request was carried out, and the recommendations were approved by the Board of Control on Feb. 15, 1943, as was the appointment of Dr. Cason as Director of the Department of Medicine, a position which he held until July 1, 1957. In addition to the Director, a faculty composed of Florida physicians was recommended to the Dean of the Graduate School and presented to the Board of Control for approval. These men were appointed on a dollar a year salary basis. Much care was given to the selection of this faculty, both by the Committee and the physicians who were requested to act in an advisory capacity. Its members have remained available through the years to present courses on a variety of subjects at the request of the component county medical societies.

In 1939, the Committee decided it would attempt to present highly specialized courses for physicians in special fields in which they were interested. With the financial assistance of the Florida Tuberculosis and Health Association, the first such course to be presented was on diseases of the chest and was under the direction of Dr.

David T. Smith of Duke University School of Medicine, Durham, N. C. In 1940, a three day special course in cardiovascular diseases was held during the week's short course. Dr. Paul Dudley White, who had accepted the invitation to give this course, was unable to do so and appointed Dr. Ashton Graybiel to take his place. This course was well attended and well received. Because of the inability to secure medical lecturers these special courses were abandoned during World War II, but were resumed in 1947.

The financial status of the Committee has always been precarious. The first year it was necessary for the Chairman of the Committee and Dr. Tillman to borrow funds from a Gainesville bank to do some temporary financing. In 1934, the Florida Medical Association guaranteed $500 a year to support the program inasmuch as the registration fees were not sufficient. Subsequently, the Association contributed a total of $1,000. The Florida State Board of Health's assistance has amounted each year to practically one half of the actual cost. In 1947, the tuition for the short course was increased from $5 to $10. The tuition for the special courses has varied from $10 to $25. Until 1949, the Chairman of the Committee provided all secretarial help as well as many other necessary expenses without remuneration. Until July 1, 1950, all monies collected were deposited by the Florida Medical Association and checked out by the Chairman, who continuously held the dual position of Director of the Department of Medicine and Chairman of the Committee. In 1950, through mutual understanding, the finances were transferred from the Association to a special account under the name of the Director, to be audited by the University of Florida.

In 1947, the employment of a part time secretary was authorized by the Committee. In 1949, through the assistance of the Florida State Board of Health, Miss Hazel Donegan, who had previously acted as secretary to the Committee from 1941 to 1947, was employed as a part time assistant to the Director. In 1950, this was made a full time position under the Graduate School of the University of Florida.

The Director recognized the mission of providing postgraduate medical education would not be fulfilled unless some provision was made for the Negro physicians of the state to attend. The Negroes were not eligible to matriculate as students at the University of Florida. This obstacle was overcome by registering them under the Florida Agricultural and Mechanical College and securing the cooperation of the Florida Medical, Dental and Pharmaceutical Association, which was their organization in Florida. The College provided a registrar and kept the records for these Negro physicians. This innovation in 1940 was enthusiastically received by the physicians of Florida, and comments by the lecturers were most favorable. In more recent years, Negro physicians holding membership in the Florida Medical Association have registered and attended these graduate courses.

In 1956, the Department of Medicine of the Graduate School of the University was incorporated into the Division of Postgraduate Education of the College of Medicine, and the 1957 courses were held in Gainesville at the Medical Sciences Building of the College of Medicine. A special course in hematology was presented on June 20-22, which was followed by the Twenty-Fifth Annual Graduate Short Course on June 24-28. The College of Medicine and the University of Florida made every possible effort to present the subjects designed for Florida physicians so that they could receive the maximum benefit. The President of the University, Dr. J. Wayne Reitz, manifested personal interest in the undertaking.



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Number 3

A Remodeling of the Educational Foundation For Practice Through Postgraduate Medical Education

William C. Thomas Jr., M.D.
GAINESVILLE

In 1892 William Henry Welch said, "Medical education is not completed at the medical school: it is only begun."[1] In recent years there has been an increasing interest and participation in postgraduate medical education by practicing physicians. This year Maurice Pincoffs restated this viewpoint when he said, "The M.D. degree is the symbol of competence for discriminating lifetime study."[2]

The remarkable gains in medical knowledge during the past 20 years have sharpened the need for more postgraduate education, and every physician who has the responsibility of patient care is acutely aware of the need for acquaintance with new facts and theories. The means by which the physician may continue his medical education can be described in four categories: reading of current journals and monographs; attendance at formal postgraduate courses; medical society and hospital staff meetings; and contact with professional colleagues. The first two methods are considered by physicians to be the most rewarding.[3]

Reading. The medical graduate, particularly after the fifth postgraduate year, is expected to keep abreast of new developments by the regular use of journals. Reading of carefully selected current medical literature is a valuable educational venture, and one which can be followed at his convenience by the physician alone. The mere mass of publications prohibits any general coverage of the field of medicine, and the variable quality necessitates discriminating judgment for proper appraisal of papers within a given field. The library of the Health Center at the University of Florida is available at all times to any physician who wishes to use it. Other fine libraries are located in all parts of the state.

Postgraduate Courses. Since World War II the number of short courses sponsored by medical institutions and societies has increased tenfold.[3] This increase not only denotes the desire of physicians to keep abreast of current developments, but also signifies an increased awareness by medical institutions of their responsibility for the continuing education of the practicing physician.

Medical education begins in the medical school and associated university hospitals. If the schools and teaching hospitals are to exercise their full potential in future medical education and human welfare, broad concepts must be adopted. Although these institutions are properly administered with emphasis on the initial education and training of the physician, it would seem highly desirable that they accept an even greater responsibility for a continuing program of education of the physician-student. The enlarged concept of the physician as a continuous student for the remainder of his professional career implies a responsibility on the part of all departments of teaching institutions for continual re-education of earlier students.

The medical school curricula are constantly revised to incorporate recent knowledge into the teaching program for the student, and over a ten year period the revisions in course material and methods of presentation are usually so extensive that the course is completely different from the one of a decade earlier. Thus, the broad foundation of the physician's medical education, which is formed during the years as a medical student and as a house officer, is the educational base upon which he subsequently must build his ultimate medical knowledge. With specialized courses, seminars, and traineeships medical societies and institutions offer excellent means for the physician to obtain advanced and detailed knowledge in any phase of medicine. A brief review, however, of the subject matter of various short courses and seminars indicates that few, if any, are designed for the remodeling of the foundation of the physician's professional education.

Assistant Professor of Medicine and Director of Postgraduate Education, College of Medicine and Teaching Hospital, University of Florida.

Since the medical school courses are being revised to incorporate new knowledge for the current student, the graduate of 10 or 20 years previously should also profit by the revisions. The magnitude and multiplicity of new developments in medicine are such as to render impossible their evaluation by any single individual. Thus, the practicing physician must compensate for lack of specific knowledge by experience and judgment based on an awareness that new knowledge has accrued in areas other than those of his particular interest. The physician would be aided immeasurably in rendering the highest quality of medical care in his practice if the wisdom gained through experience could be added to an always current foundation of medical knowledge. This ideal of maintaining a constantly up-to-date store of basic information does not seem impossible to attain.

Program at the University of Florida. At the College of Medicine and Teaching Hospital of the University of Florida, the concept of the need for continuing education of the physician has been accepted by all departments as sound educational policy. This recognition of a broad role in medical education requires that a program be developed which is accessible to the physician. The members of the Florida Medical Association are aware that an annual short course in medicine has been conducted for a number of years by the Association in conjunction with the State Board of Health, largely through the efforts of Dr. Turner Z. Cason. It is intended that short courses will be continued by the College of Medicine and that all facilities of the Health Center will be utilized. Such courses could be designed for the information of all physicians, regardless of the type of practice or degree of specialization, and could provide an opportunity to inaugurate this type of educational program. Selected advances in the basic medical, physical, or social sciences would be correlated with their application to the recognition and management of disease. Rather than an attempt to cover isolated aspects of the entire field of medicine in a long course, such a program could be divided into a series of one to two day sessions with each portion devoted to a single clinical field—pediatrics, medicine, surgery, obstetrics, and so forth. By keeping constantly in mind the basic purpose of remodeling the medical foundation to a current status, this program would complement highly specialized courses sponsored by a clinical or basic science department, but devoted to more detailed, technical aspects of a single subject.

The anticipated program for postgraduate education at the College of Medicine of the University of Florida would consist, first, of a series of basic courses devised to inform the physician of those developments which have altered previous teaching with emphasis on clinical application of the recent advances; and, second, more highly specialized short courses and seminars for those physicians who wish advanced training in particular subjects, all developed by the various clinical and basic science departments. With the completion of the J. Hillis Miller Health Center, personnel from all fields ancillary to health would participate in these programs.

Informal educational opportunities are already available, and all physicians are welcome to attend staff conferences, teaching exercises, and guest lectures at any time. A lounge has been provided in the Medical Sciences Building for visiting physicians, and the secretary for postgraduate education, who has so ably handled the administration of the short courses in recent years, is available now in Gainesville to arrange appointments with faculty members and conference visits. A calendar of forthcoming hospital and medical school activities is now sent to all physicians and hospitals of the state as well as other interested persons.

These proposals for postgraduate education will be integrated with those programs already in effect in this state. Cooperation and advice of the Committee on Medical Postgraduate Course of the Florida Medical Association, the Florida State Board of Health, and the organized specialty groups in the state are necessary and will be of inestimable value in presenting an effective, comprehensive program. Criticisms and suggestions which will assist us at the College of Medicine are eagerly sought. It is both a privilege and a challenge to develop a program of continuing education which will meet the high standards demanded by the profession in the state. With the cooperation and assistance of the practicing physicians, an ultimately successful program will be achieved so that it may become a reflection of the high ideals and purpose of those engaged in medical practice.

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VOLUME XLIV
NUMBER 3

THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 2411 JACKSONVILLE, FLORIDA

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A New Responsibility — Precipitating Factors

It has become increasingly important for the physician to focus his attention on the precipitating factors of illness. It is not sufficient, for example, for him to make the diagnosis of myocardial infarction due to arteriosclerosis of the coronary arteries; now he must consider possible contributing causes.

A man had a heart attack. It was a hot day. Did circulatory collapse from heat exhaustion play a part in the immediate illness? Perhaps the unfortunate man with the heart attack had played three sets of tennis that afternoon. Did his game have a causative effect?

A 55 year old auto salesman retired because of frequent attacks of precordial pain. If he walked out to the parking lot, or if he became agitated in making a sale, he would experience anginal pain. His electrocardiogram showed changes compatible with healed infarction.

After some 10 months of rest on the beaches, an occasional movie, and frequent afternoons of fishing off the river bridges, he felt greatly improved. His attacks of angina were much less frequent. He had gained 15 pounds.

Thursday afternoon he was driving his car home from the garage. His car was sideswiped. Fortunately, there was no injury except to the fender; however, he became angry, and a heated argument ensued. On the way home he had to stop at the roadside because of precordial pain. A moment's rest and two nitroglycerine tablets enabled him to drive on in comfort.

That evening at dinner, he suffered a severe attack of precordial pain, was taken by ambulance to the hospital, and remained there several weeks. The diagnosis was myocardial infarction.

It is not sufficient for the physician to recognize the myocardial infarction and skillfully guide the treatment. He must focus attention on the possible precipitating factors.

Did the auto accident play a part in bringing on the immediate illness? Does the insurance liability for accidental injury cover this illness? These are largely legal questions; yet the legal questions cannot be answered with justice unless the medical questions are answered first.

Similar questions are raised every day and sooner or later must touch each physician. The

easy way out is for him to give a hasty answer, or to let his sympathies affect his answers, or simply to say, "I won't appear in court." At the same time, these questions must be answered by the medical profession. The truth in these matters is at the mercy of the physician.

Modern society, with the development of insurance coverage and laws for the protection of the laboring man, has thus dropped a new responsibility in the lap of the physician. It has become necessary for each one to focus his attention on the precipitating factors in disease and to interpret cause and effect without bias.

He must develop his thinking and knowledge so that he can discern the difference between precipitating factors in disease and mere coincidence. He must use the same careful intellectual honesty and precise unemotional thinking in these matters that he brings to bear in the treatment of the sick man.

Time has brought a new job for the physician. He must assume a responsibility in decisions of a sociomedical nature in the care of his patients, and he must learn more of the relationship of environmental factors to the precipitation of illness. There is a new responsibility in diagnosis—know precipitating factors and evaluate them honestly.

Dedicated Service

The Florida Medical Association has been blessed throughout its long history with able leaders who have charted the course through the years that has brought it to its present high status. Among them is one who for more than a quarter of a century has cherished a vision of graduate medical education in Florida of which the profession could be proud and from which it would benefit increasingly. To the realization of this objective Dr. Turner Z. Cason of Jacksonville has given of his time and effort unsparingly across the years. In the early thirties, he began pioneering the way that has led to the presentation of medical postgraduate courses within the state year after year by many of the nation's most distinguished teachers.

As recounted elsewhere in this medical education number of The Journal, Dr. Cason was wise enough to associate the Association's program with the Graduate School of the University of Florida, envisioning as he did a great future for Florida in the field of medical education. Steadfastly, in forthright fashion he has persevered, serving as chairman of the Association's Committee on Medical Postgraduate Course since this committee was established in 1932, an appointment which he continues to hold. Likewise, he served as Director of the Department of Medicine of the Graduate School of the University from the time that office was created in 1942 until he relinquished the post in July 1957. Over this long period, in this dual capacity he had rendered valiant service far above and beyond the call of duty. He has laid the groundwork ever more firmly for the consummation of his dream, which, fortunately, he is privileged to see realized in that the Division of Postgraduate Education of the College of Medicine, created in 1956, is now in a position to take over the graduate medical education program as an integral part of the University's unique and comprehensive venture into the field of medical education.

Honor to whom honor is due. Congratulations to this dedicated doctor on a goal attained —the happy fruition of a sound concept and a constructive endeavor which redounds to his credit and to the benefit and glory of Florida medicine.

Modern Medicine Moves Ahead "AMA in Action"

The fantastic pace at which modern medicine moves ahead today is a bit bewildering to the average doctor. Were it not for the assurance that he does not stand alone, he might indeed be overwhelmed. Standing ready to help the individual physician are his county medical society, his state medical society and the national confederacy of these organizations — the American Medical Association. Always the key man in this organizational system, he nevertheless finds in it his mainstay.

An engrossing picture of promoting the science and art of medicine and the betterment of public health is graphically portrayed in the AMA's new booklet entitled "AMA in Action." Here is the story of the pooled efforts of his colleagues to provide every physician with the innumerable informational sources and services he needs. In addition, he finds here a yardstick of progress and an inspirational account of his profession which will stir his pride and be heart-warming.

Take, for example, the realm of medical education, with which this issue of The Journal is

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particularly concerned. It is a matter of national pride that America's physicians are among the best trained in the world. They have won this high rating largely because of the AMA efforts since 1900 to elevate the standards of medical education. By taking the initiative, setting standards for training competent physicians and putting an inspection and approval program into existence, the AMA put the diploma mills out of business. Today, all 82 medical schools are approved, and four new schools under development are aiming for provisional approval.

The AMA's Council on Medical Education and Hospitals in liaison with the Association of American Medical Colleges continues to inspect medical schools periodically, evaluating curriculum, teaching staff, physical and clinical facilities and administration. It serves, however, in a guidance rather than a regulatory capacity. Because internships and residencies are a vital part of a physician's training, the AMA Council cooperates with the American Boards of Medical Specialties and other organizations in evaluating hospital teaching programs and lists those approved.

Evidence of the dedication of physicians to the task of training top-notch doctors is the fact that almost half of the physicians teaching in the nation's medical schools receive no pay for their services. Additional proof is found in the more than five million dollars contributed voluntarily by doctors to the American Medical Education Foundation since 1952 to aid medical schools financially.

These and many more highlights of the AMA in action are set forth in the booklet, which every physician will wish to read and keep for basic reference material. Through its pages every member of the Florida Medical Association will want to look with the AMA toward better medicine, toward better patient care, toward better distribution of medical services, toward a better informed public and toward better public health.

The physicians who founded the AMA back in 1847 were concerned about standards of medical education, safety of drugs and medical quackery. They agreed on collaborative action as the best approach to solving these and other problems confronting the medical profession. How right they were, and how proud they would be that the now century-old AMA stands today as a world leader in medicine and a respected voice in American affairs.

The Medical Secretary

The value of good public relations and efficient business methods in the practice of medicine has been brought home to physicians in recent years in many ways. At the local level, the physician has recognized more and more that his secretary or office aide is a key person in the areas of public relations and business administration for medical practice. Too, he has appreciated more and more that he can reduce his work load per patient by delegating certain activities in his office to properly trained personnel.

Since 81 per cent of all self-employed physicians now have at least one full or part time secretary, nurse or technician, these physicians will welcome efforts to improve training for these assistants. A research study,[1] participated in by the American Medical Association, was made recently to provide a basis for the development and improvement of educational programs in schools for the training at a high level of secretaries for physicians' offices. Its ultimate objectives were to provide physicians with the most competent business—medical assistance possible and to raise the level and status of physicians' secretaries by improving the quality of their work.

Conclusions were based on information supplied by approximately 500 excellent medical secretaries and on personal interview with physicians and business educators. The activities performed in physicians' offices were classified into three catagories: (1) highly technical medical activities which, under normal conditions, only a physician can perform; (2) semitechnical medical activities which may be performed satisfactorily by medical office personnel under the supervision of the physician, and (3) business office activities of a routine or management nature which are ideally performed by the secretary or aide.

The survey points out that "physicians are not making maximum use of their extensive training when they unnecessarily perform semitechnical medical and business activities. To help doctors determine what responsibilities can be delegated properly to office personnel, a system for assigning duties is currently being prepared by the American Medical Association and will be furnished to medical societies within the next few months.

Proper medical secretarial training and training for medical aides should be at the post-high-

school level with a four-year college-degree training program preferable to a shorter course, according to the study. Only schools with strong business training and strong science departments can offer the kinds of courses and the quality of training that are desirable. The survey findings regarding course content in medical secretarial training programs will be particularly valuable to business schools and junior colleges training medical office employees, to medical societies working with such schools to expand existing courses or develop new ones, to societies sponsoring short courses for doctors' aides and to medical assistants' organizations interested in "postgraduate education" for members.

The study, which also tabulates physicians' opinions about necessary personal qualities in the ideal medical secretary, will provide a pattern for screening candidates for medical office positions. It is expected that eventually an evaluation guide based on the survey will be prepared to aid physicians in hiring properly qualified secretaries.

On the basis of the survey, steps which medical associations and medical secretary–assistants groups can take to help provide a greater force of better-trained aides in the future include:

1. Encourage schools with the necessary personnel and facilities to offer high quality medical secretarial training.

2. Recruit high school graduates for high quality medical secretarial training.

3. Organize or assist in organizing refresher courses in medical office administration for the employed medical secretary and assistant.

4. Persuade persons currently employed as medical secretaries to increase the effectiveness of their work through additional training in school and/or while at work.

5. Point out to physicians the importance of employing well qualified medical secretaries and renumerating them adequately.

Undoubtedly, the physician's secretary can save him a tremendous amount of time by performing many of the semitechnical and most of the business activities in the office—if she is well trained and possesses certain important personal qualities.

1. The Medical Secretary: Her Duties, Training and Role on Medical Team, a brochure prepared by the American Medical Association, provides a summary of a research study report entitled Knowledges, Skills, and Personal Qualities of Medical Secretaries by Harold Mickelson, Ed.D., 1957.

"Stress of Life" Author to Address Florida Academy of General Practice St. Petersburg, Nov. 1-2, 1957

On an impressive list of speakers who will address the Eighth Annual Scientific Assembly of the Florida Academy of General Practice at St. Petersburg on November 1 and 2, the name of Dr. Hans Selye, Surgeon, emerges in a shining aura of distinctive accomplishments to hold a special place of interest for doctors in Florida.

Born at Vienna, Austria, in 1907, Dr. Selye descends from three generations of physicians. At 18, while a medical student at Prague, he was greatly encouraged in his research on the stress syndrome by not only the moral support, but also the financial backing secured for his work, of Sir Frederick Banting, the discoverer of insulin.

By 1931, Dr. Selye had secured his M.D. and Ph.D. degrees at the German University of Prague. The year 1942 found him at McGill University, Montreal, Canada, with a D.Sc. degree. He continued his experiments in endocrinology, often meeting with strong opposition to his theories. One scientist said, "I don't always agree with Hans Selye, but I have yet to prove him wrong." The British Medical Journal added, "No theory in living memory has stimulated research to such an extent."



Hans Selye, M.D., Ph.D.

During the decade 1937-1947 Dr. Selye held professorships in Histology and Biochemistry at Johns Hopkins and McGill universities and, in 1947, he was Expert Consultant to the Surgeon General, U. S. Army. Recently, in New Orleans he dedicated a "stress laboratory" sponsored by Tulane and Louisiana State universities.

He is the author of a dozen books, the latest of which is "The Stress of Life," McGraw-Hill Book Company, with translations in Swedish, German and French. The book again emphasizes his belief that "Stress is a part of life. It is a natural by-product of all our activities; there is no more justification for avoiding stress than for shunning food, exercise or love." From his analysis of stress in animals, his colleagues, friends and himself, he evolved the motto: "Fight always for the highest attainable aim, but never put up resistance in vain."

When asked for his own stress-quotient for his apparently successful conformity to the stress of life, he replied, "I do work pretty hard, but I am not sure that this is due to any special strength or energy. In fact, it may be the reverse. I just seem to get so much fun out of my work that I do not have the strength and energy to stay away from it."

The Assembly will be honored by the presence of Dr. Malcom E. Phelps, President of the American Academy of General Practice, and one of its "founding fathers." The members of the Florida Chapter are deeply gratified that Dr. Phelps has found the time to meet with them and address them.

Other speakers will include Dr. George T. Harrell Jr., Dean of the University of Florida College of Medicine; Dr. Ellard M. Yow, Department of Internal Medicine, Baylor University; Dr. Franklin J. Evans, Legal Medicine, University of Miami School of Medicine; Dr. Robert A. Hingston, Professor of Anesthesiology, Western Reserve University; Dr. Donald A. Covalt, Associate Professor, Department of Physical Medicine and Rehabilitation, New York University College of Medicine; Dr. Edward F. Hartung, Associate Professor, Clinical Medicine, New York University Postgraduate Medical School; Dr. James Hughes, Professor of Pediatrics, University of Tennessee; Dr. W. D. Snively Jr., Medical Director, Meade Johnson Company, Instructor in Fluid Balance, St. Mary's Hospital, Evansville, Ind., and University of Colorado Graduate School.

Graduate Medical Education Diabetes Association Meeting Gainesville, October 24-26

The fifth annual meeting of the Florida Clinical Diabetes Association will be held October 24, 25 and 26, 1957, in Gainesville at the Medical Sciences Building of the College of Medicine of the University of Florida. Dr. Edward R. Smith, President, urges all members to make reservations early for motel or hotel accommodations and also to send for tickets to the football game between Louisiana State University and the University of Florida on Saturday, October 26 at 2:30 p.m. Contact the Division of Postgraduate Education of the College of Medicine of the University of Florida for assistance.

Dr. William R. Jordan of the Medical College of Virginia, Richmond, Va., and Dr. Sidney Davidson of Lake Worth are among the speakers. The program will include lectures on diabetes mellitus and other phases of metabolism.

Cleft Palate Seminar Miami, November 8-9

The Nemours Foundation and the South Florida Cleft Palate Clinic, in cooperation with the Florida Crippled Children's Commission and the University of Miami School of Medicine, are pleased to announce an event of major interest to those concerned with the care of cleft palate patients.

The concept of the team approach for the proper habilitation of the cleft palate child has gained wide acceptance in recent years. This trend is partially due to research and teaching by the University of Illinois Cleft Palate Center. Four members of the staff of the Illinois Cleft Palate Center will present a seminar on "Modern Concepts in Multi-Professional Planning for Cleft Palate Patients" at the McAllister Hotel in Miami on Friday and Saturday, November 8 and 9, 1957. The registration fee of $10 will include a dinner on Friday night.

The speakers will be Edward Lis, M.D., pediatrician and Director of the Cleft Palate Center; Samuel Pruzansky, D.D.S., orthodontic consultant and Coordinator of Research; Herbert Koepp-Baker, Ph.D., speech pathologist and original organizer of the Center; Herbert Kobes, M.D., Director of the University of Illinois Division of Services for Crippled Children. The formal pro-

gram will be presented all day Friday and on Saturday morning. Saturday afternoon will be devoted to discussion and the presentation of any patients that members of the audience wish to bring for consultation. Members of all professions concerned with the cleft palate patient are cordially invited to participate.

For additional information, contact Dr. George Balber, Chairman of the South Florida Cleft Palate Clinic, 515 N. E. 15th St., Miami 32, or Dr. William R. Stinger, Director of the Florida Crippled Children's Commission, Box 1028, Tallahassee.

Fifth International Congress of Internal Medicine

The International Society of Internal Medicine has announced that its Fifth International Congress of Internal Medicine will be held at the new Sheraton Hotel in Philadelphia on April 24-26, 1958. This will be the first meeting of the society outside of Europe. In making the announcement, the International Society's President, Sir Russell Brain, who is also President of the Royal College of Physicians of London, said, "The Executive Committee of the Society has chosen the United States for its Fifth Congress in response to an invitation extended by the American College of Physicians and with the objective of securing greater American participation in its deliberations and of allowing foreign members, at first hand, to learn more about American developments in the medical sciences."

The previous Congresses, at two year intervals, were held in Paris, London, Stockholm and Madrid. At those meetings, however, the United States, as well as many other nations throughout the world, was represented. The present membership of the society, including 48 nations, is about 3,000.

This society, the only international one embracing all aspects of internal medicine, was organized in 1948 and largely at the instigation of Professor Nanna Svartz of Stockholm, the physician to the King of Sweden. It was her contention that the various branches of internal medicine should be kept in touch with one another, as is accomplished in North America by the American College of Physicians, and that this should be done on a truly international basis. She also emphasized the importance of purely personal and nonpolitical contacts among physicians of different countries.

The objectives of the society, as stated in its Statutes, are "to promote scientific knowledge in internal medicine, to further the education of the younger generation and to encourage friendship among physicians of all countries." The members are "specialists in internal diseases, acknowledged as such and accepted by the appropriate national societies of internal medicine."

The first president of the International Society was Professor A. Gigon, of Basel, Switzerland. He was succeeded, in 1952, by Dr. Svartz and she, by Sir Russell Brain, the President of the Royal College of Physicians of London.

At the Philadelphia Congress it is planned, through lectures and panels, to analyze medical achievements of worldwide significance, to evaluate certain apparent problems and to chart courses of action designed to enhance technical knowledge and to aid in the continuing war against disease. At the same time, the plan includes such social and cultural activities as will tend to promote cooperation, friendship and mutual understanding among physicians and peace among their countries.

The 1958 Annual Session of the American College of Physicians will occur in Atlantic City, April 28 to May 2, immediately following the Philadelphia Congress. The members of the Congress are invited to attend all the scientific programs and extensive exhibits, the foreign members on a purely courtesy basis.

T. Grier Miller, M.D., Philadelphia, is the President of the Congress; Edward R. Loveland, F.A.C.P. (Hon.), is the Secretary-General; and Mr. J. Malcolm Johnston, Philadelphia, the Treasurer.

Medical District Meetings

Dr. S. Carnes Harvard, of Brooksville, Chairman of the Council of the Florida Medical Association, has announced that the 1957 Medical District Meetings will be held the last four days of October—in Panama City, Oct. 28; in Clearwater, Oct. 29; in Orlando, Oct. 30, and in Fort Pierce, Oct. 31.

Dr. Harvard and his district councilors are arranging an outstanding scientific program which is scheduled for publication in the October issue of The Journal.

Each member of the Association is urgently requested to be present at the meeting in his district.

STATE BOARD OF HEALTH

Asiatic Influenza

At the present time (Aug. 5, 1957) confirmed outbreaks of Asiatic influenza have been reported from nine states in the United States. To date none have been reported in Florida, and the Central Laboratory of the State Board of Health has examined only 13 specimens from suspect cases, in three of which there was evidence of exposure to the Asian strain of influenza A virus. Due to the delay between preparation of these reports and publication, this situation may be considerably changed by September. A misstatement due to elapsed time in publication occurred in this column in the August issue of The Journal when a report stated that "none of the presently available influenza vaccines confer protection against this strain of influenza virus." At the time of preparation of this present report, one manufacturer is marketing a polyvalent influenza vaccine containing the Asian strain of influenza A, and five other manufacturers are in various stages of production of either monovalent or polyvalent influenza vaccine containing the Asian strain.

It is expected, however, that only four million doses will be ready by mid-September for civilian use, and production goals call for 60,000,000 doses by February, at which time the anticipated epidemic of Asian influenza may well have already occurred.

Because of these limited supplies, it is recommended that physicians, nurses, hospital employees and other health personnel whose services are imperative for the care of the sick be immunnized. Also, if sufficient vaccine becomes available, other key persons in essential community services and persons with chronic debilitating disease could be given preference for influenza immunization.

The State Board of Health has no plans at present for purchase or distribution of influenza vaccine through County Health Departments.

There would seem to be only the advantage of less expense in immunizing with a monovalent vaccine, as compared with a polyvalent vaccine. The recommended dosage for adults is 1 cc. subcutaneously. Preliminary studies have indicated that the intradermal method using 0.1 cc. is not practical with the present influenza vaccine. Vaccine protection is estimated at 70 per cent; it begins 10 to 14 days after injection and remains for six months to one year. None of the influenza vaccines available for civilian use prior to July 15, 1957, contained the Asian strain of virus.

EMORY UNIVERSITY SCHOOL OF MEDICINE
Atlanta, Georgia
Announces
SIX DAYS
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CARDIOLOGY
(January 13-18, 1958)

Major Problems of Heart Disease will be discussed by Members of the Emory University Faculty and the following visitors:

A. Corlton Ernstene, M.D., Choirmon, Division of Medicine, Clevelond Clinic, Clevelond, Ohio
Dwight E. Horken, M.D. Assistont Clinicol Professor of Surgery, Horvord Medicol School; Surgeon, Peter Bent Brighom Hospitol; Chief of Deportment of Thorocic Surgery, Mount Auburn ond Molden Hospitols, Boston, Moss.
Helen B. Toussig, M.D., Associote Professor of Pediotrics, The Johns Hopkins University School of Medicine; Director of the Children's Heort Clinic of the Horriet Lone Home, The Johns Hopkins Hospitol, Boltimore, Md.
Eugene A. Stead, M.D., Professor ond Choirmon, Deportment of Medicine, Duke University School of Medicine, Durhom, N. C.
Ancel B. Keys, M.D., Professor of Medicine, University of Minnesoto; Director of the Loborotory of Physiologicol Hygiene, University of Minnesoto School of Public Heolth, Minneopolis, Minn.
Edword S. Orgoin, M.D., Professor of Medicine, Duke University School of Medicine; Director, Cordiovosculor Diseose Service, Duke Hospitol, Durhom, N. C.
E. Grey Dimond, M.D., Professor ond Choirmon of the Deportment of Medicine; Director of the Cordiovosculor Loborotory, University of Konsos Medicol Center, Konsos City, Konsos.
Gene H. Stollermon, M.D., Associote Professor of Medicine, Northwestern University, Chicogo, Ill.

Tuition fee: $100.00
Write: Postgraduate Teaching Program, Emory University School of Medicine, 69 Butler Street, Atlanta 3, Georgia

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Apostolos A. Kartsonis, of Jacksonville, announce the birth of a daughter, Mary Pia, on May 30, 1957.

Marriages

Dr. Horace A. Day, of Orlando, and Miss Irene R. Ziegler were married in Orlando on July 14, 1957.

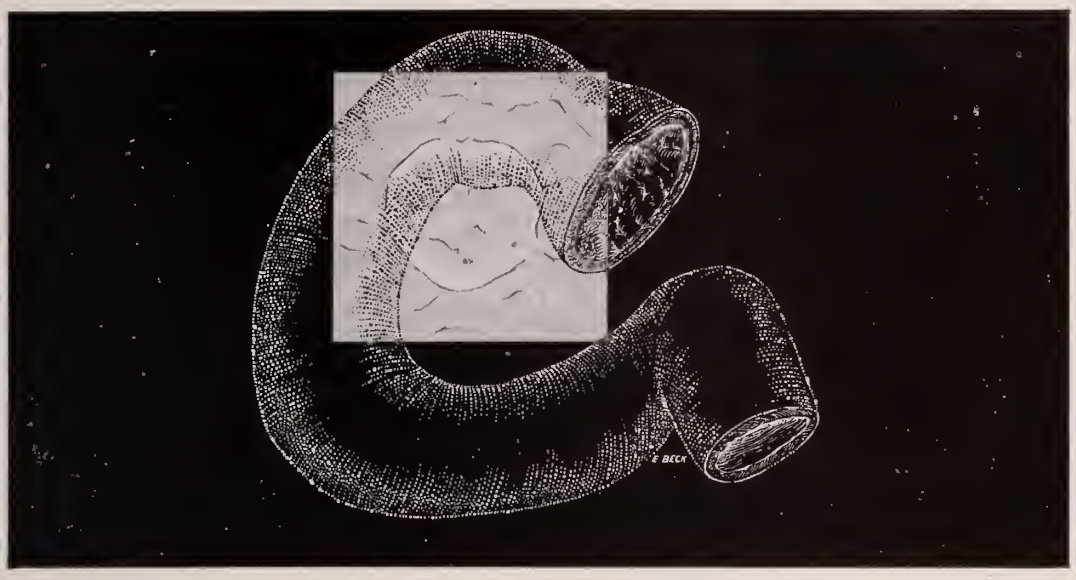
Deaths—Members

Bechman, George E., Jacksonville	March 27, 1957
Smith, James A., Sanford	February 19, 1957
Geiger, Hugh S., Kissimmee	July 6, 1957
Henry, Gordon F., West Palm Beach	April 25, 1957
Melvin, Alexis M., South Miami	June 18, 1957
Webb, Walter D., St. Augustine	June 11, 1957
Griffin, Thos. R., St. Petersburg	July 20, 1957
Merrick, Thomas D. Sr., Miami	July 9, 1957
Counts, Noah T., Cocoa	June 24, 1957
Driskell, Simon E., Jacksonville	July 5, 1957
Torbett, Ralph S., Tampa	April 28, 1957
Myers, Lucien E., Winter Park	July 11, 1957

Deaths—Other Doctors

Engle, Ralph Landis, Coral Gables	March 22, 1957
Weeks, Joseph C., Lake City	June 29, 1957
Faver, Henry M., Tampa	July 7, 1957
Caraker, Charles T. Jr., Perry	July 13, 1957

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1. Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Am. J. M. Sc. *232*:156 (Aug.) 1956.
2. Sun, D. C. H., and Shay, H.: Arch. Int. Med. *97*:442 (April) 1956.
3. Rafsky, H. A.; Fein, H. D.; Breslaw, L., and Rafsky, J. C.: Gastroenterology *27*:21 (July) 1954.
4. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.
5. Silver, H. M.; Pucci, H., and Almy, T. P.: New England J. Med. *252*:520 (March 31) 1955.

SEARLE

OTHERS ARE SAYING

Editorial

Medical ethics are basically the same as ethics for any other homologous group of humans working together in a common cause. They differ only in specialized particulars concerned with the service or activity which may be unique to a particular group, and of little or no concern to another. Ethics are principles. They represent generations of experience by trial and error. As such, they are blueprints for the practices and behavior of the individuals who make up the group. They distill the best of the past, sustain the needs of the present, and point to the possibilities for improvement of the future. The Golden Rule is the solid core of all ethics.

Like the law of gravity, the root principle of ethics cannot change. Interpretation and application inevitably vary to a greater or lesser degree from period to period in history. Variations come from special situations and changes of circumstance. Even when they occur after prolonged and careful consideration by adequate numbers representative of the group, they are dangerous. If a majority of the group agrees to change certain traditional interpretations, and promulgate a new plan or rule of application in order to adapt to a real and permanent change in society or environment, it may and should very definitely do so — *provided* the alteration does not extend the structure dangerously beyond the supporting foundation of essential basic principles.

This is the age of ballyhoo. Old P. T. Barnum would turn green with envy at any assistant publicity director of a third-rate cosmetics firm. Even the so-called "allied commercial organizations" who make apparatus and the newer physik have fallen under the spell and utter strange and often incomprehensible claims for their products. It's not surprising that many physicians seriously question the wisdom of abiding by old-fashioned rules for the preservation of dignity and rigid honesty. These virtues wax and wane in popularity. Now they are at rather low ebb throughout the world. We are told we should try to foster and certainly participate in a moral and religious rededication. If Medicine wishes to provide its expected share in leadership at this important period in our history, we should be slow to change our present rules for individual conduct and behavior. Liberalization at this time may well be misinterpreted as capitulation. The advantages of a more liberal interpretation on scores of thorny points are many and they tempt us mightily. At times, it seems we're engaged in a tough fight with one good arm tied behind us by our own foolish choice. We do have a most extraordinary birthright, however, and if you look close, some of those immediate advantages which might be gained look a bit like pottage! Let's be sure what we're trading for!

D. F. M.
The Bulletin, Dade County Medical Association
September, 1956.

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STATE NEWS ITEMS

The Emory University School of Medicine at Atlanta has announced a postgraduate course in cardiology for six days beginning January 13, 1958. Members of the Emory University faculty and eight eminent specialists from throughout the United States will discuss the major problems of heart disease. The tuition fee is $100. Information may be obtained by writing Postgraduate Teaching Program, Emory University School of Medicine, 69 Butler Street, Atlanta 3, Georgia.

Dr. Charlotte C. Maguire of Orlando has been in London, England, where she served as a delegate from the United States to the Seventh World Congress of the International Society for the Welfare of Cripples.

Dr. Kenneth A. Morris has been elected president of the Jacksonville Chapter of the American College of Surgeons. Dr. Samuel M. Day has been chosen president-elect and Dr. George M. Stubbs, secretary-treasurer. Councilors are Drs. Frederick J. Waas, E. Frank McCall and James G. Lyerly Sr. All the physicians are from Jacksonville.

Dr. Thomas E. McBride of Apopka has returned from a month in North Carolina where he attended the annual pediatric seminar held at Saluda and visited clinics at Winston Salem.

Dr. Frank C. Bone of Orlando has been appointed chairman of the Central Florida Medical Meeting Committee. The meeting is held annually at Orlando.

Dr. Henry I. Langston of Blountstown has been appointed Director of the Health Department of Gulf, Franklin and Wakulla counties with headquarters at Apalachicola.

Dr. Talmadge S. Thompson of Venice has been elected president of the Lions Club there. Dr. Thompson has been a member of the Club since its founding ten years ago.

The Council on Postgraduate Medical Education of the American College of Chest Physicians will present three Postgraduate Courses on Dis-

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eases of the Chest this fall: Hotel Knickerbocker, Chicago, Oct. 21-25; Park-Sheraton Hotel, New York, Nov. 11-15, and Ambassador Hotel, Los Angles, Dec. 9-13.

Tuition for each course is $75. The most recent advances in the diagnosis and treatment of chest diseases both medical and surgical will be presented. Information may be obtained from the Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

Dr. Everett M. Harrison of Clearwater has been elected president of the Dunedin Rotary Club.

Dr. Herbert D. Kerman of Daytona Beach presented a paper on teletherapy at the recent Inter-American Symposium on the Peaceful Application of Nuclear Energy held at the Brookhaven National Laboratory, Upton, Long Island. The Symposium was attended by more than 200 scientists from the 21 American republics.

Dr. Jacob A. Glassman of Miami, Assistant Clinical Professor of Surgery at the University of Miami School of Medicine, addressed a medical meeting at Greenwood, S. C., late in August. Dr. Glassman's subject was "The Present Status of Thyroid Surgery."

The Forty-Third Clinical Congress of the American College of Surgeons will be held in Atlantic City, N. J., Oct. 14-18, 1957. Invited guests at the Congress will include medical students from 36 colleges located in the United States and Canada.

For the ninth year the Lake County Medical Society has conducted physical examinations and given immunizations for members of the National Guard of the county. This service by Society members is a part of the over-all public relations program. Dr. Thomas E. Langley of Eustis was in charge of the activity this year.

Members of the Society have also served as round up teams for conducting physical examinations among pre-school children with referrals to the individual's private physician for any needed corrections.

Drs. Alvan G. Foraker and Sam W. Denham of Jacksonville have been awarded three grants by the National Cancer Institute for research

when anxiety and tension "erupts" in the G. I. tract...

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projects. The first is for a new three year study of histochemical changes of aging in human ovaries. The other two are for continuation of present studies involving an investigation of cytochemical and cytophysical properties of intraepithelial carcinoma of the cervix and an experimental study of induced tumors in rat ovaries.

Drs. Sidney Stillman of Jacksonville and Ralph B. Spires of DeFuniak Springs have been reappointed to the State Board of Medical Examiners by Governor LeRoy Collins. A new appointment to the Board was Dr. Robert T. Spicer of Miami.

Dr. George T. Harrell Jr. of Gainesville. Dean of the College of Medicine, University of Florida, has been appointed a member of the Nuclear Development Commission by Governor LeRoy Collins.

Dr. Hugh A. Carithers of Jacksonville has been appointed by Governor LeRoy Collins to a four year term on the State Children's Commission.

Dr. Edward Jelks of Jacksonville has been reappointed to a new four term as a member of the Duval County Welfare Board.

Dr. Chas. J. Collins of Orlando has been elected president of the State Board of Health succeeding Dr. Herbert L. Bryans of Pensacola who served as president for the past 17 years.

The annual meeting of the Southeastern Allergy Association will be held in Charleston, S. C., on November 1-2, according to announcement by Dr. Clarence Bernstein of Orlando, president.

A postgraduate course entitled "Recent Advances in Diagnosis and Treatment of Arrhythmias" has been scheduled at Mount Sinai Hospital of Greater Miami November 18-22. There will be evening sessions. The course will be conducted by Dr. Richard Langendorf of Chicago, Research Associate in Cardiovascular Diseases at Michael Reese Hospital.

Dr. Leland H. Dame of Winter Park has been elected to the Royal Society of Health in London, England.

when anxiety and tension "erupts" in the G. I. tract...
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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.



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Please send me dozen copies of the new, illustrated Knox Reducing booklet based on Food Exchanges.

Your Name and Address.

Dr. Francis W. Glenn of Coral Gables has returned from Indianapolis, Ind., where he attended a meeting of the Board of Governors of The American Fracture Association. Dr. Glenn is Regional Vice President of the Association.

The Eighteenth Annual Meeting of The American Fracture Association is being held in the Hotel Cortez, El Paso, Texas, Sept. 30-Oct. 2.

The meeting will be preceded and coordinated with The University of Texas Postgraduate School of Medicine, El Paso Division, which will meet Sunday, Sept. 29, at the El Pasco County Medical Society. The University of Texas Program is approved Category I by the American Academy of General Practice. The American Fracture meeting is approved Category II by the American Academy of General Practice.

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1. Wolf & Wolff, *Human Gastric Function*

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1. Locket, S.: Brit. M.J. *1*:809 (Apr. 2) 1955.

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2. Wright, W.T., Jr., et al.: J. Kansas M. Soc. *57*:410 (July) 1956.

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Rauwiloid is recognized as basal medication in all grades and types of hypertension. In combination with more potent agents it proves synergistic or potentiating, making smaller dosage effective and freer from side actions.

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In moderate to severe hypertension this single-tablet combination permits long-term therapy with dependably stable response. Each tablet contains 1 mg. Rauwiloid (alseroxylon) and 3 mg. Veriloid (alkavervir). Initial dose, 1 tablet t.i.d., p.c.

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NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Archer, Lester, Homestead
Bozeman, James D., Orlando
Brown, John O. (Col.) Miami
Castleberry, Jesse W., Orlando
Chambers, Julius B., Winter Park
Creel, Frank L., Pensacola
Daniel, William R., Orlando
Dillard, Edgar A. Jr., Boynton Beach
DiLorenzo, Vincent J., Dundee
Doggett, Thaddeus H., Miami
Dunsworth, William P., Tampa
Ellenbogen, Nina C., Miami Beach
Epps, Earle W., Lakeland
Fomon, John J., Miami
Hicks, John H., Miami
Kass, Paul, North Miami
Kelly, Alexander J. Jr., Tampa
Levine, Oscar, Miami
Maxey, Edward S., Stuart
Mellion, Anson J., Jacksonville
Newhouser, Lloyd R., Miami
Samartino, Gaetano T., Coral Gables
Shorey, Winston K., Miami
Suarez, George J., Tampa
Turke, George J. Jr., Miami
Tyler, Lockland V. Jr., Pensacola
Walton, Thomas P. III, Tampa
Williams, R. Reche Jr. (Col.) Tampa
Ziffer, Albert M., Orlando

OBITUARIES

Guy Wilkerson Heath

Dr. Guy Wilkerson Heath of West Palm Beach died in that city on Feb. 3, 1957. He was 62 years of age.

Dr. Heath was born in 1894. He received his medical training at the Tulane University School of Medicine in New Orleans, where he was awarded the degree of Doctor of Medicine in 1920. Upon completion of an internship and a residency at Macon Hospital in Macon, Ga., he engaged in the practice of medicine for a short time in Ruston, La., before coming to Florida.

In 1924, Dr. Heath was licensed to practice in Florida. He located in West Palm Beach and

when anxiety and tension "erupts" in the G. I. tract...

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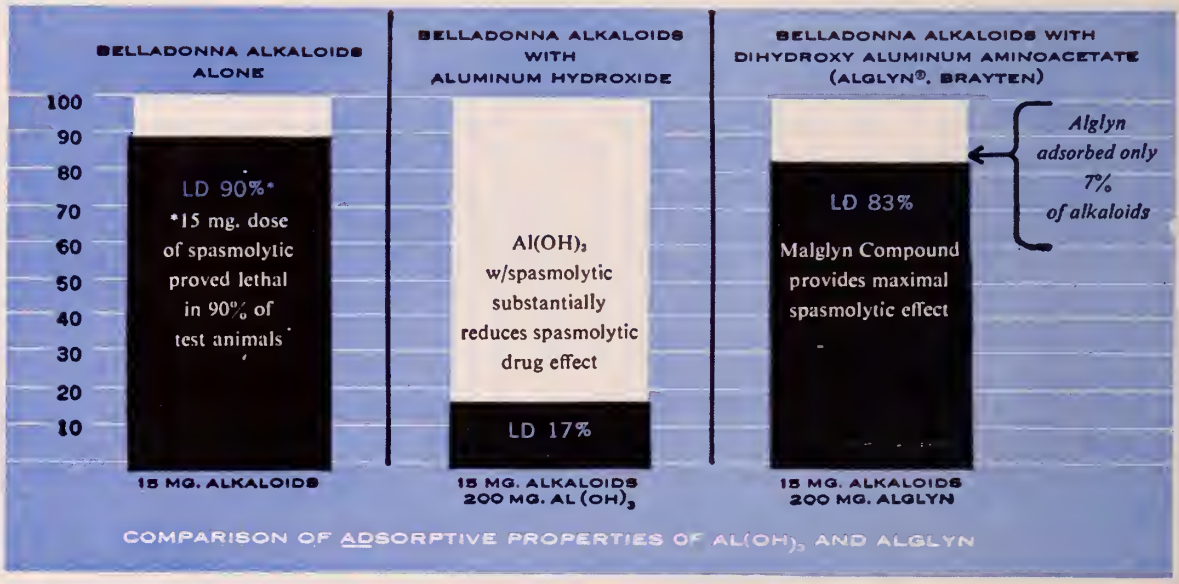
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For both rapid and prolonged antacid effect, with consistently effective spasmolytic and sedative action, rely upon MALGLYN for treatment of peptic ulcer and epigastric distress.

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dihydroxy aluminum aminoacetate, N.N.R.	0.5 GM.
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phenobarbital	16.2 MG.

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continued to practice there for 33 years. His specialty was obstetrics and gynecology. Through the years he practiced his profession faithfully and brilliantly as one of its outstanding and most revered members.

Dr. Heath was a member of the Palm Beach County Medical Society. Since 1925 he had held membership in the Florida Medical Association, and he was also a member of the American Medical Association and his specialty organizations.

Surviving are the widow, the former Miss Lillian Mosher, and one son, Guy W. Heath Jr.

Arthur McGugan

Dr. Arthur McGugan died in Denver, Colo., on May 28, 1957, at the age of 86 years.

Dr. McGugan was born in New Glasgow, Ontario, in 1870. He received his early education in Canada and was graduated from the University of Michigan Medical School in 1892.

Dr. McGugan specialized in Neurology. His career included serving as Head of the Department of Neurology of the University of Michigan Medical School; Assistant Physician and Clinical Director of the Michigan State Hospital; Professor of Neurology and Psychiatry at the University of Colorado School of Medicine; Special Lecturer in Neurology at the Boston University School of Medicine; Director of Special Research for the Department of Mental Disease of the State of Massachusetts; and Consultant in Neurosurgery to the American Expeditionary Force.

Dr. McGugan lived in Winter Park from 1935 to 1951. He was an honorary member of the Orange County Medical Society, the Florida Medical Association and the American Medical Association.

Surviving is his daughter, Mrs. John Hitch, of Denver.

Harrison G. Palmer

Dr. Harrison G. Palmer died at his home in St. Petersburg on Feb. 9, 1957. He was 80 years of age.

Born in Michigan in 1877, Dr. Palmer received his medical training in Chicago. He was awarded the degree of Doctor of Medicine in 1903 by the Bennett Medical College, now a part of

(Continued on Page 298)



Combined Estrogen-Androgen Therapy Proved 96% Effective in Preventing Postpartum Breast Engorgement[1]

Dual Steroid Approach also Successful in Osteoporosis

Of more than 4 million babies born in the United States this year, approximately 75 per cent will not be breast fed.[2] Combined estrogen-androgen therapy will effectively suppress lactation and prevent postpartum breast engorgement in these mothers.

Osteoporosis also ranks high on the list of present day medical problems because of the increasing older population.

In either condition, combined estrogen-androgen therapy produces a complementary metabolic response with little or no side effects.

In postpartum breast engorgement the rationale of therapy is explained as follows: During pregnancy, the high estrogen titer exerts an inhibitory effect on the anterior pituitary, thereby preventing the release of the lactogenic hormone, prolactin. Postpartum, the estrogen level drops off suddenly, and allows the release of previously inhibited prolactin which is now free to initiate the flow of milk. Sex hormones re-establish pituitary inhibition, thus arresting the lactating process.

In Fiskio's study,[1] "Premarin" with Methyltestosterone effectively relieved postpartum breast engorgement and suppressed lactation in 96.2 per cent of his group of 267 patients. Notably absent were breast abscesses, nausea, vomiting, excessive lochia, withdrawal bleeding or virilization. Menses were re-established after the normal six week period. The lack of mental depression during the puerperium was especially gratifying.

Osteoporosis results from impairment of osteoblastic activity, and gonadal hormone decline is possibly the most prevalent cause. Estrogen stimulates osteoblastic activity and increases calcium and phosphorus retention, while androgen exerts an anabolic or protein-forming action. Prognosis for bone recalcification is good, providing therapy is continued for extended periods. The possibility of side effects is minimized because the two hormones exert an opposing action on sex-linked tissue.

Estrogen and androgen as combined in "Premarin"® with Methyltestosterone provide a treatment of choice in osteoporosis.

Recommended Dosage: (Directions refer to *yellow* tablets.)

Postpartum breast engorgement — Short duration therapy — (one week) — 3 tablets every four hours for five doses — then 2 tablets daily for rest of week. "Step-down" therapy — (10 to 15 days) — 1st day — 4 tablets; 2nd day — 3 tablets; 3rd day — 2 tablets; thereafter, 1 tablet daily for 10 to 15 days. *It is important to start therapy as soon as possible after delivery.*

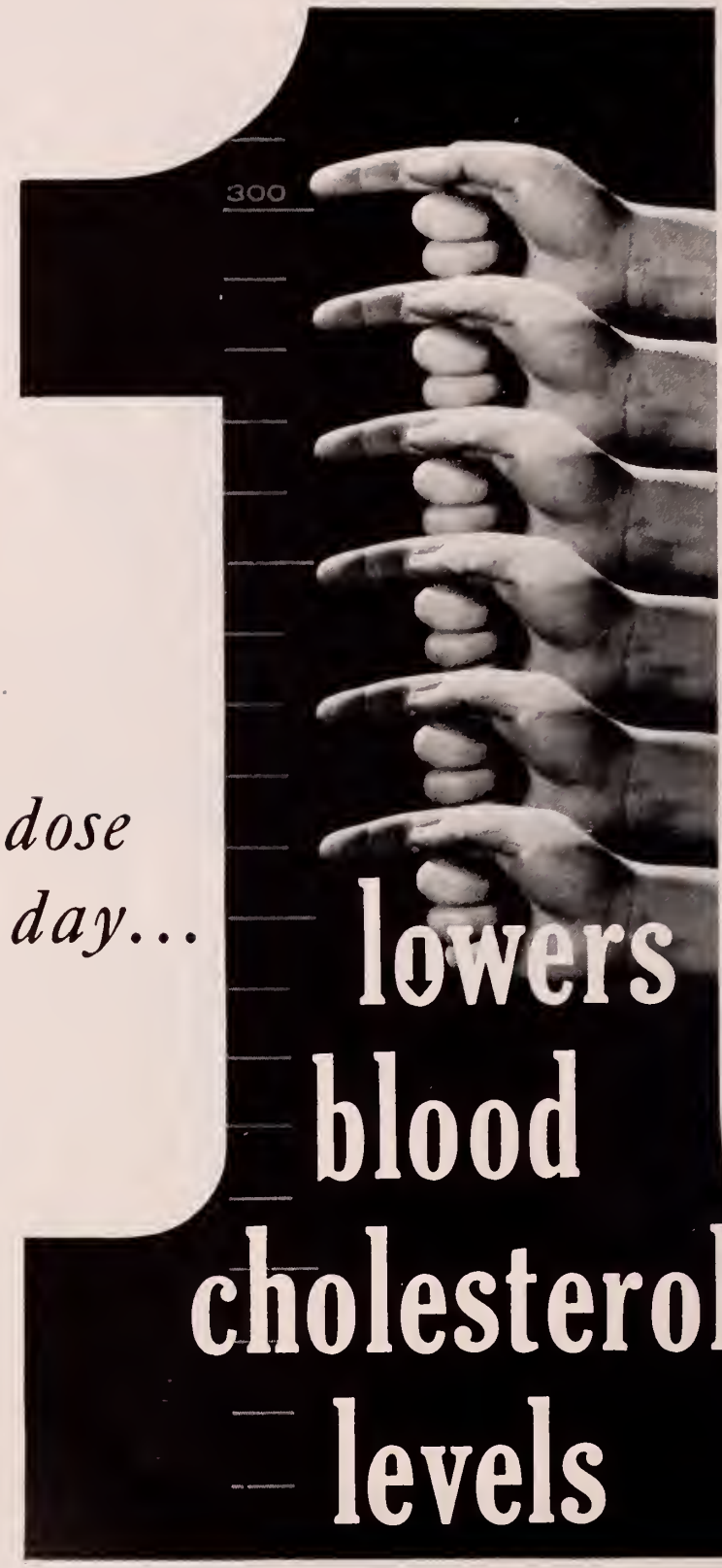
Osteoporosis: 2 tablets daily, for the first three weeks. Then 1 tablet daily thereafter. In the female it is suggested that combined therapy be given in 21 day courses with a rest period of about one week between courses, and be continued for 6 to 12 months; following this period, the patient may be maintained with cyclic therapy employing "Premarin" Tablets alone.

Supplied in two potencies: *Yellow tablets* — each contain: 1.25 mg. conjugated estrogens, equine ("Premarin") and 10 mg. methyltestosterone. *Red tablets* — each contain: 0.625 mg. and 5 mg. respectively. Bottles of 100 and 1,000.

Bibliography: Available on request.

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Each tablespoonful of emulsion contains:

Linoleic acid	6.8 Gm.
Vitamin B_6	0.6 mg.
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Arcofac is effective in small doses and is reasonable in cost to the patient



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(Continued from page 293)

the Stritch School of Medicine of Loyola University in that city. Returning to his native state, he engaged in the general practice of medicine at Newport, Mich., for nearly 30 years.

In 1936, Dr. Palmer moved to St. Petersburg and continued in general practice there up to the time of his death. He was a familiar figure in local professional circles for more than two decades. He was a member of the First Presbyterian Church and held membership in the St. Petersburg Yacht Club.

Dr. Palmer was a member of the Pinellas County Medical Society, the Florida Medical Association and the American Medical Association. He also held membership in the Medical Association of Wayne County, Michigan.

Survivors include the widow, Mrs. Marian B. Palmer, of St. Petersburg; two daughters, Mrs. James B. Wilson, of St. Petersburg, and Mrs. Raymond J. Smith Jr., of Detroit, Mich.; a sister, Mrs. S. H. Finell, of Adrian, Mich.; and a granddaughter, Miss Brenda Wilson, of St. Petersburg.

BOOKS RECEIVED

Carcinoma of the Breast: *The Study and Treatment of the Patient.* By Andrew G. Jessiman, F.R.C.S., M.D., and Francis D. Moore, M.D. Pp. 135. Illus. 21. Price, $4.00. Boston, Little, Brown and Company, 1956.

"In the light of the present evidence, what is best for the patient?" This is the question posed by the authors in their Preface, and it is the question they seek to answer in this monograph. Time and further research, they say, will prove or disprove their contentions; meanwhile these serve as a rational basis for therapy based on knowledge available at this time.

The book represents an extension of a Progress Report initially published in the New England Journal of Medicine. It is written so as to present a consistent and integrated view of the study and care of patients suffering with carcinoma of the breast, in the light of current knowledge and research on the endocrine and metabolic aspects of the surgical care of that disease.

Clinical Memoranda on Economic Poisons. Prepared by Technical Development Laboratories, Technology Branch, Communicable Disease Center, P. O. Box 769, Savannah, Georgia. U. S. Department of Health, Education, and Welfare, Public Health Service, Bureau of State Services, Communicable Disease Center, Atlanta, Georgia. Pp. 78. Price, 30 cents. Public Health Service Publication No. 476. Washington 25, D. C., Superintendent of Documents, U. S. Government Printing Office, 1957.

The U. S. Public Health Service Communicable Disease Center, Technology Branch, Technical Development

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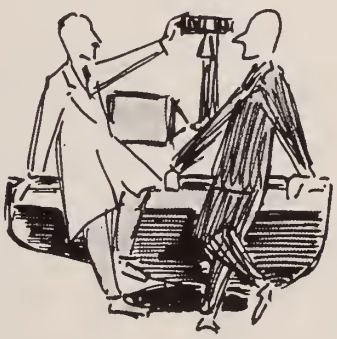
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and there'd be no mistaking the light in his eye when it falls on the handsome big-name unit whose fine appearance adds so much to the impressiveness of his office.



P.S. Somewhere along the line the matter of price would come up ... he'd most likely comment on how little he paid to get so much. Or he might even be among those who rent their x-ray machine (Picker has an attractive rental plan, you know).

P.P.S. Next best thing is to call your local Picker man in and let him tell you about this great new machine (find him in your 'phone book) or write Picker X-Ray Corporation, 25 South Broadway, White Plains, N. Y.

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Laboratories, P. O. Box 769, Savannah, Ga., advises that single copies of this bulletin will be supplied to physicians upon request as long as the supply lasts and that it is also available for purchase from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. Much of the information contained in this bulletin on the human toxicology of pesticides has been gained through reports of human poisoning cases which are furnished the Technical Development Laboratories by cooperating physicians. Physicians encountering cases of human poisoning involving pesticides are invited to report them in accordance with instructions contained in the booklet.

The Riddle of Stuttering. By C. S. Bluemel, M.D. Pp. 142. Price, $3.50 casebound, $1.50 paper bound. Danville, Ill., The Interstate Publishing Co., 1957.

The problem of stuttering remains obscure despite the efforts of many earnest workers in the field of speech disorders. Like the common cold, it is a more complicated matter than first appears. There is not one cause of the speech disorder, this author explains, but there is a combination of at least three different causes. In the speech impediment itself, there are five major components, with several minor components. Thus the problem of stuttering is complex.

The author seeks an answer to the riddle of stuttering in the field of psychiatry. The approach is different from that of the academic speech therapist, and the conclusions and the therapy are quite different. Nevertheless, the goals of all workers in the field of speech disorders are identical — to assist the stutterer in attaining fluency. The author presents his conclusions here for the appraisal of the speech correctionist and the stutterer himself.

Four 12 inch long play Speech Therapy recordings are available at $3.00 each. All proceeds from the sale of the book and the recordings have been assigned by the author to the American Speech and Hearing Foundation.

Principles of Urology: *An Introductory Textbook to the Diseases of the Urogenital Tract.* By Meredith F. Campbell, M.S., M.D., F.A.C.S. Pp. 622. Illus. 319. Price, $9.50. Philadelphia, W. B. Saunders Company, 1957.

The twofold purpose of this book is to instruct the student in the broad fundamentals of Urology and to serve as a practical guide for the physician who is not a urologic specialist, as he encounters urologic problems. The author observes in the Preface that this is not intended to be a complete reference textbook nor an armchair urology, adding that the conceit implied by its writing is founded on an experience of 35 years in the teaching of Urology to both undergraduates and graduate students of medicine.

A brief consideration of urologic semantics is followed by a short syllabus of the more frequently employed urologic terms, and a brief review of the more important aspects of urogenital tract anatomy and physiology is included as an introductory refresher. Urologic symptoms and their potential significance as indications for special urologic examination are discussed, while the pathogenesis, clinical aspects, diagnosis and treatment of the more common urologic diseases are considered adequately, it is believed, to the needs of active daily general practice either in the office or at the bedside. Special effort has been made to instruct the reader in the requisites of physical and laboratory examination and diagnostic study up to the point of cystoscopic investigation or major urosurgical therapy. Minor urologic office procedures such as meatotomy and the passage of catheters and sounds are illustrated. A useful and stimulating inclusion in the book is a chapter of questions with page references to the answers.

Dr. Campbell, who is the author of several well known works on Urology, is Emeritus Professor of Urology, New York University; Consulting Urologist to Bellevue Hospital, New York, to Variety Childrens Hos-



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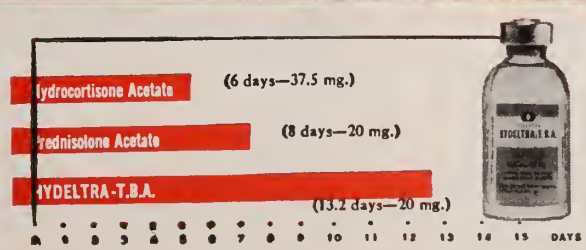
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pital, Miami, and to St. Francis Hospital, Miami Beach; and Lecturer in Urology; University of Miami School of Medicine.

General Urology. By Donald R. Smith, M.D. Pp. 328. Price, $4.50. Los Altos, Calif., Lange Medical Publications, 1957.

This volume represents the latest in a series of concise medical publications on clinical specialties. It is written for the medical student and the medical practitioner who has not specialized in urology but whose practice requires a working familiarity with the diagnostic and therapeutic technics available for the management of the genitourinary diseases and disorders. In order to serve both groups the author has combined both the practical and the theoretic aspects of his subject. In the preface he observes that although many serious urologic diseases excite few, if any, symptoms, most can be discovered by a medical examination which includes a P.S.P. renal function test, simple radiographic technics, and, above all, a careful urinalysis. He advises the reader to devote particular attention to the section on urinalysis, for a properly performed urinalysis is a very valuable clue to many urologic diagnoses. Wherever possible, excretory (intravenous) rather than retrograde urograms have been used as illustrations since they are available to the nonspecialist and are superior in many ways to retrograde studies. Selected references to the recent urologic literature have been appended to appropriate chapters for the guidance of those who wish to investigate further any specific disorder.

The author is Clinical Professor of Urology and Chairman of the Department of Urology of the University of California School of Medicine. His teaching ability combined with his wide selection of well chosen x-rays and the artist's excellent drawings make this a particularly useful book for the medical student and the practicing physician.

The Care of the Expectant Mother. By Josephine Barnes, M.A., D.M. (Oxon.), M.R.C.P. (London), F.R.C.S. (England), F.R.C.O.G. Pp. 270. Price, $7.50. New York, Philosophical Library, 1956.

During the last 30 years, the importance of regular and systematic examination and investigation of the pregnant woman has been recognized. The dramatic reduction in maternal and infant mortality during this period may be attributed in large measure to the improved care which mothers receive during pregnancy. This book has been written as a practical guide for all who undertake the management of pregnancy. Much of it is based on routine teaching given to medical students and pupil midwives in lectures, antenatal clinics and antenatal ward rounds. Its aim is to be simple and yet comprehensive. The three sections of this readable study deal with normal pregnancy, abnormal pregnancy, and diseases complicating pregnancy. There are numerous illustrations. The author, who is Obstetrician and Gynaecologist to Charing Cross Hospital and the Elizabeth Garrett Anderson Hospital, London, England, presents in this volume material of interest to the obstetrician, the general practitioner and the medical student.

Battle for the Mind. By William Sargant. Pp. 266. Price, $4.50. Garden City, N. Y., Doubleday & Company, Inc., 1957.

How can an evangelist convert a hard-boiled sophisticate? Why does a PW sign a "confession" he knows is false? How is a criminal pressured into admitting his guilt? Do the evangelist, the PW's captor, and the policeman use similar methods to gain their ends? These and other compelling questions are discussed in this book. The author spells out and illustrates the basic technic used by evangelists, psychiatrists and brain-washers to disperse the patterns of belief and behavior already established in the minds of their hearers, and to substitute

(Continued on Page 312)

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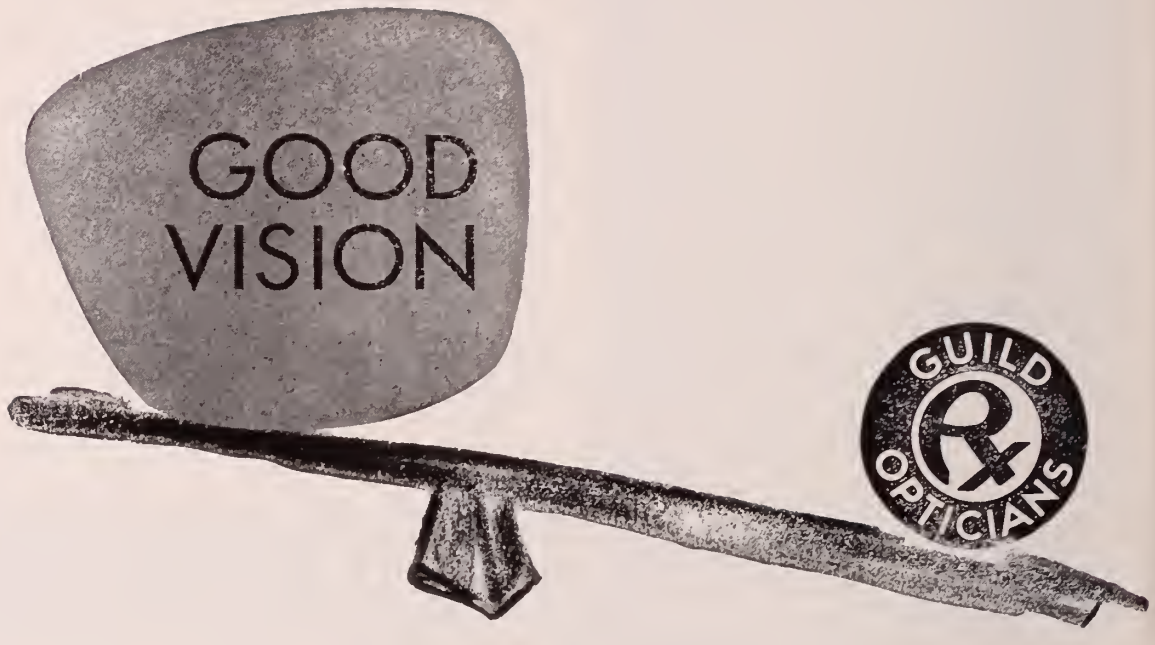
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Meat...

and the Need for Adequate Protein in Therapeutic Nutrition

Liberal protein intake is considered to be of therapeutic value in a wide variety of pathologic conditions.[1] Advances in the understanding of protein metabolism indicate that dietary protein should provide amino acids in proportions paralleling physiologic needs.[2, 3] In experimental studies with animals, low protein diets supplying amino acids disproportionate to needs have been shown to effect physiologic harm by depressing growth, by inducing amino acid and B-vitamin deficiencies, and by causing deposition of fat in the liver.[4]

Hence not only the *amount* of protein but also its *quality* (in terms of its amino acid proportions) is important. It has been suggested[1] that for therapeutic purposes about two-thirds of the ingested protein come from foods of animal source, whose protein resembles human body protein in amino acid interrelationships. Depending on the needs of the patient, the therapeutic diet may supply 1.0 or more grams of protein per kilogram of body weight. Adequate caloric intake is required to protect the dietary protein from dissipation for energy purposes.

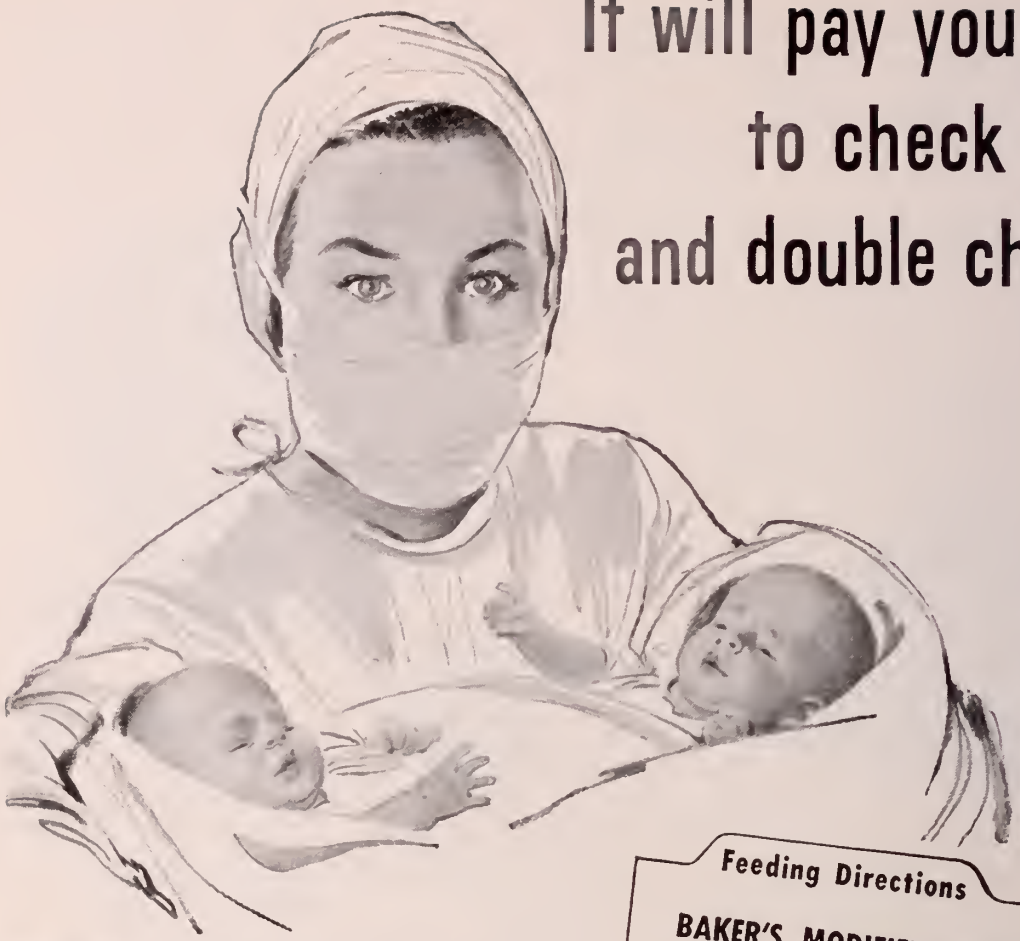
Meat, with its high content of top-quality protein, holds a prominent place among foods which supply this essential for establishing satisfactory levels of amino acids in physiologic proportions. It also contributes valuable amounts of B vitamins and essential minerals—nutrients which play a basic role in intermediate metabolism.

1. Proudfit, P. T., and Robinson, C. H.: Nutrition and Diet Therapy, ed. 11, New York, The Macmillan Company, 1955, pp. 314-320.
2. Harper, A. E.: Amino Acid Imbalance, Toxicities and Antagonisms, Nutrition Rev. *14*:225 (Aug.) 1956.
3. Amino Acid Requirements of Adult Man, Nutrition Rev. *14*:232 (Aug.) 1956.
4 Amino Acid Imbalance and Supplementation, Editorial, J.A.M.A. *161*:884 (June 30) 1956. Council on Foods and Nutrition, American Medical Association: Importance of Amino Acid Balance in Nutrition, J.A.M.A. *158*:655 (June 25) 1955.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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Check these facts!

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Double Check the results you get!

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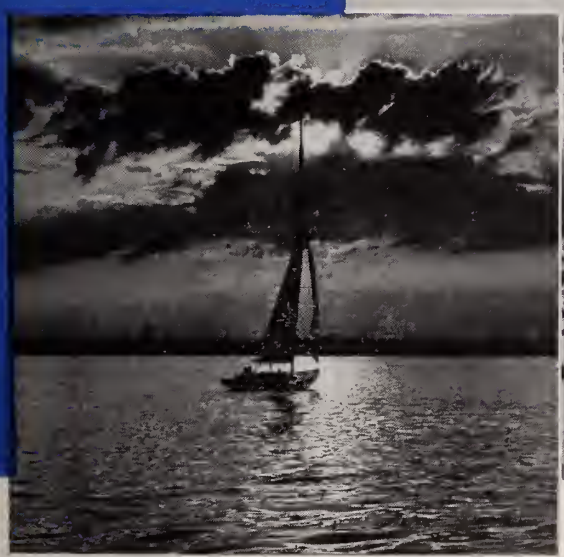
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through provision of natural belladonna alkaloids in optimal ratio, with phenobarbital

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DONNATAL TABLETS
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Hyoscyamine Sulfate	0.1037 mg.
Atropine Sulfate	0.0194 mg.
Hyoscine Hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

DONNATAL EXTENTABS®
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Each Extentab (equivalent to 3 Tablets) provides sustained 1-tablet effects...evenly, for 10 to 12 hours—all day or all night on a single dose.

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who "did
himself in"

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For persons who overestimate their physical capacity —as with this do-it-yourself dad—chronic fibrositis may be a postscript to a weekend of accomplishment.

SIGMAGEN therapy is encouraged in the treatment of chronic fibrositis to alleviate pain and prevent progression of the disorder to fibrosis and calcification.

SIGMAGEN provides doubly protective corticoid-salicylate therapy. METICORTEN® (prednisone) and acetylsalicylic acid are combined to provide additive antirheumatic benefits and rapid analgesic effect. These dual clinical values are enhanced by aluminum hydroxide to counteract excess gastric acidity and by ascorbic acid to help meet the increased need for this vitamin during stress situations.

Therapy should be individualized. *Acute conditions:* 2 or 3 tablets 4 times daily. Following desired response, gradually reduce daily dosage and discontinue. *Subacute or chronic conditions:* Initially as above. After satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

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Prednisone	0.75 mg.	Aluminum hydroxide	75 mg.
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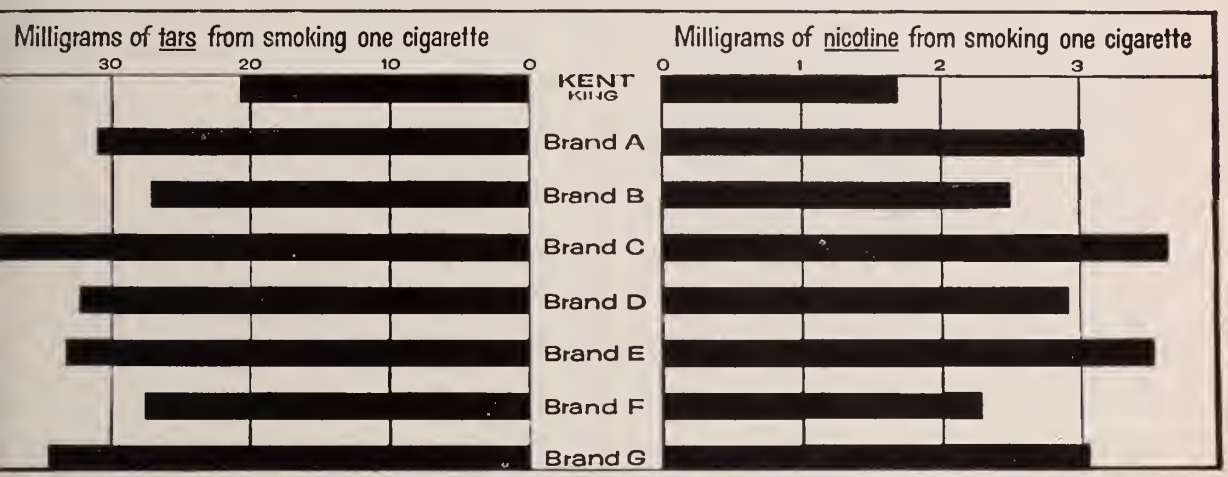
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(Continued from Page 302)

new patterns for them. There is much hopeful news here concerning the treatment of the mentally ill. Dr. Sargant makes clear the relation of the new "mind-drugs" to his topic and includes a chapter on how to avoid being indoctrinated and on how to consolidate changes of belief and behavior when desirable.

Dr. Sargant is now Physician in Charge of the Department of Psychological Medicine at one of England's oldest and best known medical schools. He is present President of the Section of Psychiatry of the Royal Society of Medicine, and also Registrar of the Royal Medico-Psychological Association. In 1938-1939 he spent a year on a Rockefeller Travelling Fellowship at Harvard, where he was Research Fellow in Psychiatry. In 1947-1948 he was invited to become Visiting Professor of Neuropsychiatry at Duke University. Altogether he has visited or worked in the United States on four different occasions in the past 18 years.

The Compleat Pediatrician: *For General Practitioners, Pediatricians, Interns and Students.* By W. C. Davison, M.D., and Jeana Davison Levinthal, M.D. Ed. 7. Pp. 272. Price, $4.25. Durham, N. C., Duke University Press, 1957.

This comprehensive summary of pediatric facts is an invaluable guide to practical, diagnostic, therapeutic and preventive pediatrics. In condensed form, it covers the diagnosis, treatment and prevention of disease, and the feeding, growth, development and guidance of children, emphasizing (1) the recognition of ill children, their diseases and what to do for them, and equally important, (2) routine child care (physical, mental and emotional) from conception through adolescence. This seventh edition has been written because of the great progress in antibiotics, anticonvulsants, antihistaminics, electrolytes and steroids, and the necessity of removing all of the now obsolete "formerly accepted pediatric facts."

In the preparation of this edition, the distinguished senior author was joined by his daughter as co-author. She is now an Instructor in Pediatrics at the University of Michigan School of Medicine. Dr. Davison, Professor of Pediatrics at Duke University School of Medicine, writes in the Preface: "This book represents an effort to compile and condense those practical pediatric facts, which though essential, usually slip from memory; it is an attempt to combine in one volume the information usually found in several, which should be consulted for more complete study. It is hoped that this book may serve as a ready reminder to be carried, like a stethoscope, in a physician's pocket or bag to jog his memory on possibilities, but it cannot do his thinking for him. Memory is treacherous, a mere reminder often makes a physician the master of a situation." It should be an essential for any practitioner caring for children, and has aptly been described as a world almanac of pediatrics.

Drugs in Current Use 1957. Edited by Walter Modell, M.D., F.A.C.P. Pp. 152. Price, $2.00. New York, Springer Publishing Company, Inc, 1957.

This is the third volume of an annually revised listing of drugs in common use. It includes well established drugs, some still on trial, old ones of questionable or purely traditional value but still likely to be encountered and, in addition, some drugs seen only as the cause of poisoning and some that are obviously doomed but which, for sentimental reasons, one is reluctant to discard. The purpose is to provide a concise statement of the principal pharmacologic characteristics of drugs in current use; major uses; physical properties; absorption; actions, both therapeutic and toxic; mode of administration; preparations; dosage; and specific antidotes against poisoning when these are available. In other words, the book provides a capsule account of the data essential to the sensible exploitation and safe handling of a drug. In most cases some special warnings are issued which draw attention not only to dangerous reactions and contraindications

Current Concepts in

Infant Carbohydrate Metabolism

The adequately balanced diet must contain carbohydrate as an essential nutrient. Though some carbohydrate becomes available to the body from the transformation of protein and fat, these sources contribute minor amounts of the total carbohydrate requirement.

Body energy comes from the oxidation of carbohydrate and fat but carbohydrates are oxidized preferentially. The brain derives its supply of energy exclusively from the oxidation of carbohydrate. Besides, the infant's requirement for energy is unusually high and can be most readily satisfied by carbohydrate.

All tissues of the body constantly require and use carbohydrate under all conditions. Even a temporary fall of the blood sugar below critical levels is accompanied by serious disability. However, the amount of carbohydrate in the body at one time is very small. It would sustain life for only a fraction of a day. Consequently, the infant must be offered carbohydrate frequently to yield a generous proportion, usually over half, of the total caloric intake.

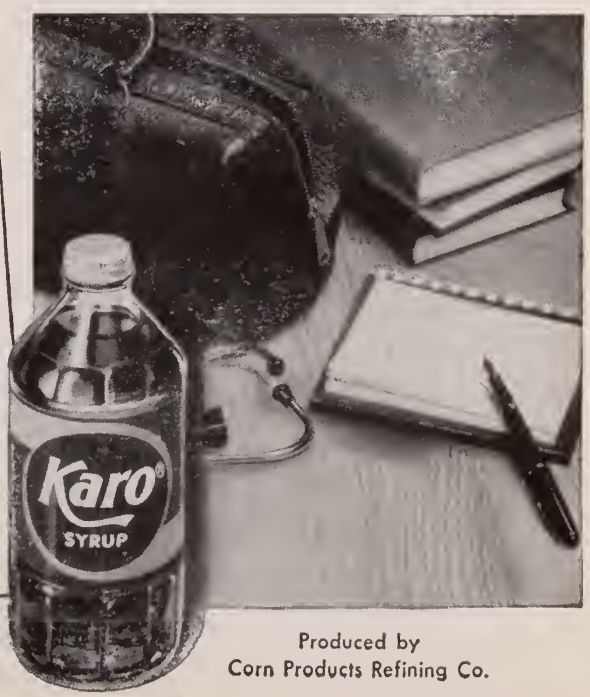
The breast-fed infant receives about 12 gms. of carbohydrate per kilo body weight, while the artificially fed infant receives about 8 to 14 gms. per kilo. In the choice of an added carbohydrate, we must consider adaptability, tolerance, digestability, absorption, fermentability, and irritation to the intestines.

The same problems of infant feeding recur from generation to generation, but solutions may differ with each era. The carbohydrate requirement for all infants is as completely fulfilled by KARO® Syrup today as a generation ago. Whatever the type of milk adapted to the individual infant, KARO Syrup may be added confidently because it is a balanced mixture of low-molecular weight sugars, readily miscible, well tolerated, palliative, hypoallergenic, resistant to fermentation in the intestine, easily digestible, readily absorbed and non-laxative. It is readily available in all food stores.

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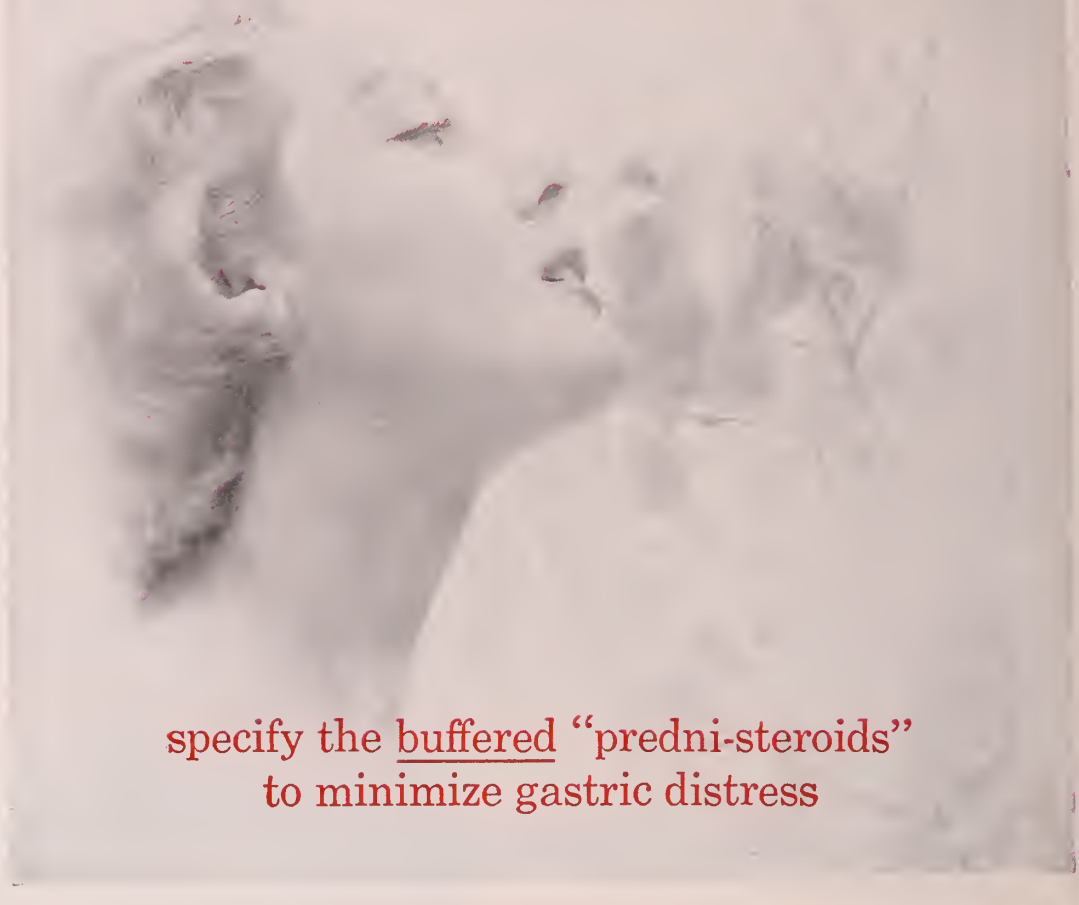
INFANTS' CALORIC REQUIREMENTS

AGE (Months)	CALS. Per 24 hrs.	CALS. Per Kilo	CALS. Per Pound
1	500	115	52
2	625		
3	675		
4	725	110	50
5	750		
6	800		
7	825	100	45
8	850		
9	875		
10	900	95	43
11	950		
12	1000		
24	1200	90	40



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combined steroid-antacid therapy . . .

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but also to instability, special requirements for storage and for prevention of deterioration, and time limits before significant loss in potency or change in pharmacologic properties.

Short essays on pharmacologic groups of drugs are also included in the alphabetic listing. These essays deal with the problems of use, and actions and dangers characteristic of drugs as a group. Therapeutic groups of drugs in common use are also listed. Drugs are described under their official names wherever these have been established. Because of widespread usage, proprietary names and synonyms could not be ignored in a realistic presentation, the more common ones are usually included.

The Fight for Fluoridation. By Donald R. McNeil. Pp. 246. Price, $5.00. New York, Oxford University Press, 1957.

The American Dental Association, the American Medical Association, the American Public Health Association, the United States Public Health Service, the National Research Council, and almost every national scientific body are among more than 200 nationally known organizations which have endorsed fluoridation. Yet fluoridation remains a controversial subject, even in some of the cities where it has been adopted. In fact, the impact of the fluoridation struggle has had far-reaching effects on the social and political equanimity of hundreds of towns and cities in the nation. Local arguments are hot and heavy, and for years to come many communities will go to the polls to decide the question of fluoridation.

For this accurate and absorbing history of fluoridation, Donald R. McNeil, Associate Director of the Wisconsin State Historical Association, studied all the important published literature on the subject from 1916 to 1956 as well as original manuscripts and the correspondence of the leading figures. The research that preceded fluoridation and the struggles that have surrounded it as a public health measure are his story, one that suggests parallels with the fights for vaccination and pasteurization. It is a dramatic tale of trial and error, enthusiasm and skepticism, seriousness and humor, and, above all, success.

Ciba Foundation Symposium on Bone Structure and Metabolism. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc. Pp. 299. Illus. 121. Price, $8.00. Boston, Little, Brown and Company, 1956.

"Bone Structure and Metabolism" covers the subject from fundamental knowledge of anatomy and histology through biochemistry and physiology to clinical medicine. Here one can find much basic information on bone and, "rather surprisingly, much lamentation about our ignorance of many clinical problems." The book presents in full, with only a minimum of editing, the proceedings of a symposium on Bone Structure and Metabolism, which was among the small international conferences organized at the Ciba Foundation in London in 1955.

A partial table of contents includes: structure of bone from the anatomic to the molecular level; structure of bone salts; the histologic remodeling of adult bone, an autoradiographic study; fibrogenesis and the formation of matrix in developing bone; the mucopolysaccharides of bone; autoradiographic studies of the formation of the organic matrix of cartilage, bone, and tissues of teeth; in vitro uptake and exchange of bone citrate; the magnesium content of bone in hypomagnesaemic disorders of livestock; the mechanism of nutrition in bone and how it affects its structure, repair, and fate on transplantation; studies on the repair of fractures using ^{32}P; metabolic studies on vitamin D; variations in sensitivity to vitamin D; present knowledge of parathyroid function, with especial emphasis upon its limitations; vascularity of bone in relation to pathologic studies; some observations on experimental bone disease, and bone as a critical organ for the deposition of radioactive materials.

when anxiety and tension "erupts" in the G. I. tract...

in spastic and irritable colon



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BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

The Official American Medical Association Book of Health. Edited by Dr. W. W. Bauer. Ed. 1. Pp. 320. Price, 35 cents. New York, Dell Publishing Company, Inc., 1957.

This pocket size book on health is a Dell first edition popularly priced and compiled for the laity from recent articles and editorials in Today's Health, of which Dr. W. W. Bauer is Chief Editor. The approach is through the modern concept of health having three separate components — the physical, the mental or emotional, and the spiritual. The book contains material from a wide variety of sources — medical, dental, public health, educational, sociological, governmental, and lay.

"It is not a solemn book," explains Dr. Bauer in the Introduction. "Health, in our view, is not a solemn subject. It is — or ought to be— a happy one. But physical health alone does not assure happiness. With emotional balance and spiritual strength added, however, an individual can be happy even in adversity. We have tried to select material for happy people. We have included some light material which may entertain you and help you to keep your perspective on health; perhaps it will also serve to brighten a dark moment in a dreary day. As you read the pages which follow, we hope you will come to regard good health as a means to a fuller, richer life, and not as an end in itself." Certainly the laity will profit by reading this comprehensive little volume.

Liver, Biliary Tract and Pancreas, Part III of Volume 3, Digestive System, The Ciba Collection of Medical Illustrations. By Frank H. Netter, M.D. Pp. 165. Color plates 133. Price, $10.50. Summit, N. J., Ciba Pharmaceutical Products, Inc., 1957.

Publication of the third volume in the estimated nine volume, 20 year project to create for medicine the first definitive collection of authentic, full color illustrations of every significant segment of the human body and diseases that affect it has just been announced by Ciba Pharmaceutical Products, Inc. The artist for the entire series is the country's leading medical illustrator, Dr. Frank H. Netter of Norwich, Long Island.

Volume 3 is being developed in three parts. "Liver, Biliary Tract and Pancreas," now available, is actually Part III of this third volume. The decision to publish this section before Parts I and II was based on a survey which showed that the subject covered in Part III was second only to the nervous system in interest to the medical profession. The topics included in Part III are: normal anatomy of the liver, biliary tract and pancreas, signs and symptoms of disease, diagnostic tests, congenital anomalies, host/parasite relationships and blood supply to tissues. Part I will deal with the upper digestive tract; Part II with the lower digestive tract. Part III also incorporates a new feature designed to enhance the book's value as a versatile, multipurpose aid to clinicians, teachers, researchers and students, namely, literature references for the convenience of those wishing to follow up any topics discussed in the text.

According to Dr. Ernst Oppenheimer, editor of The Ciba Collection, all anatomic details, "whether essential or bordering on the trivial," are recapitulated by Dr. Netter. "All available texts and other publications, particularly the pertinent literature of the past 25 years, are read, checked, rechecked and compared." All volumes in the Collection are sold at cost as a service to the medical profession and medical students.



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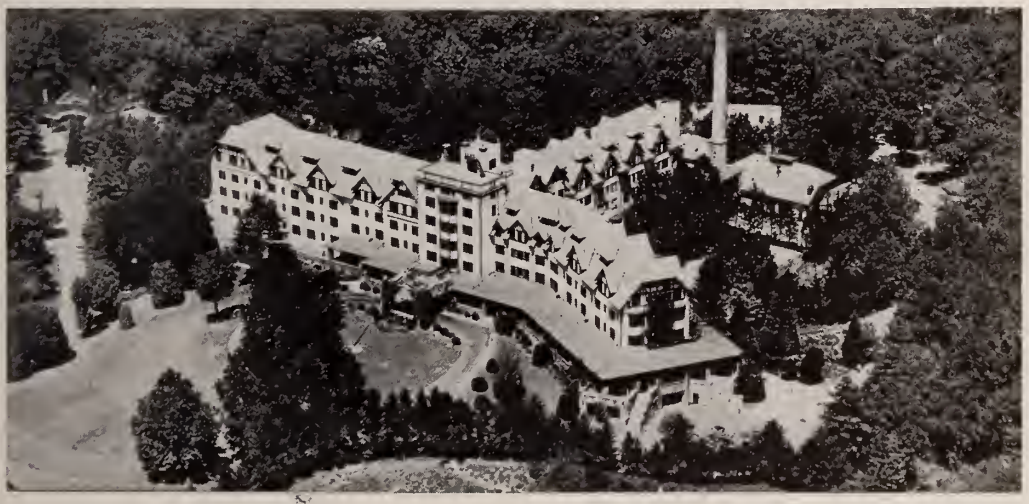
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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Glenn O. Summerlin, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	63
***Bradford, Gilchrist, Union**				
Bay	John J. Benton, Panama City	Lloyd B. Harrison Jr., Panama City	1st Tues.	29
Brevard	Myron L. Habegger, Rockledge	Louis C. Jensen Jr., Rockledge	2nd Tues.	50
Broward	Walter J. Glenn Jr., Fort Lauderdale	Garland M. Johnson, Fort Lauderdale	4th Tues.	170
Collier	James A. Craig, Naples	Ethel H. Trygstad, Naples	3rd Wed.	9
Columbia	Thomas H. Bates, Lake City	Laurie J. Arnold Jr., Lake City	1st Mon.	11
***Baker**				
Dade	Walter W. Sackett Jr., Miami	Vincent P. Corso, Miami	1st Tues.	825
DeSoto-Hardee-Highlands-Glades	Godfrey L. Beaumont, Sebring	Theodore W. Weeks Jr., Sebring	1st Tues.	28
Duval	Leo M. Wachtel, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	332
***Clay**				
Escambia	Paul F. Baranco, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	111
Franklin-Gulf	Photis J. Nichols, Apalachicola	William F. Wager, Port St. Joe	Last Wed.	7
Hillsborough	Madison R. Pope, Plant City	James A. Winslow Jr., Tampa	1st Tues.	224
Indian River	Walter W. McCorkle. Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	10
Jackson-Calhoun	William W. Richardson, Graceville	Francis M. Watson, Marianna	Quarterly	16
Lake	Fred A. Vincenti, Mount Dora	J. Basil Hall, Tavares	1st Wed.	31
***Sumter**				
Lee-Charlotte-Hendry	James L. Bradley, Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	George S. Palmer, Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	76
Madison	Julian M. DuRant, Madison	A. Franklin Harrison, Madison		8
Manatee	Joseph A. Gibson, Bradenton	Warren G. Darty, Palmetto	2nd Tues.	31
Marion	John D. Lindner, Ocala	Robert L. Gibson, Ocala	3rd Tues.	36
***Levy**				
Monroe	Robert W. Reid, Key West	Joseph J. Scarlet, Key West	1st Thurs.	13
Nassau	Benj. F. Dickens, Fernandina Beach	David D. Bennett Jr., Callahan	1st Thurs.	9
Orange	Frank J. Pyle, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	219
***Osceola**				
Palm Beach	Edward W. Wood, Lake Worth	Robert Y. Wheelihan, Riviera Beach	4th Mon.	158
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	19
Pinellas	Percy H. Guinand, Clearwater	Whitman C. McConnell, St. Petersburg	1st Mon.	260
Polk	John P. Tomlinson Jr., Lake Wales	Charles Larsen Jr., Lakeland	2nd Wed.	115
Putnam	Alfred P. Peretti, Palatka	Norman B. Edgerton, Palatka	2nd Tues.	11
St. Johns	Milton Segal, St. Augustine	William J. Gibson, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	John M. Gunsolus, Stuart	Adrian M. Sample, Fort Pierce	3rd Thurs.	28
Sarasota	Samuel E. Kaplan, Venice	James E. Kicklighter, Sarasota	2nd Tues.	69
Seminole	Gordon D. Stanley, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee-Hamilton-Lafayette	Hiram B. Curry, Jasper	William P. Blackmon, Jasper	1st. Sat.	11
Taylor	Charles R. Wiley, Perry	Ralph J. Greene, Perry	Last Fri.	6
***Dixie**				
Volusia	Arthur Schwartz, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	91
***Flagler**				
Walton-Okaloosa-Santa Rosa	Ralph B. Spires, DeFuniak Springs	Howard A. Parker, Valparaiso	3rd Tues.	28
Washington-Holmes	Walter H. Shehee. Chipley	L. H. Paul, Bonifay		4
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*Ferguson, J. T., and Linn, F. V. Z.: Antibiotic Med. & Clin. Therapy *3*:329, 1956.

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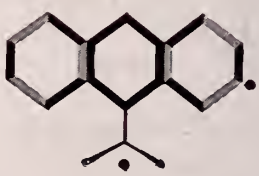
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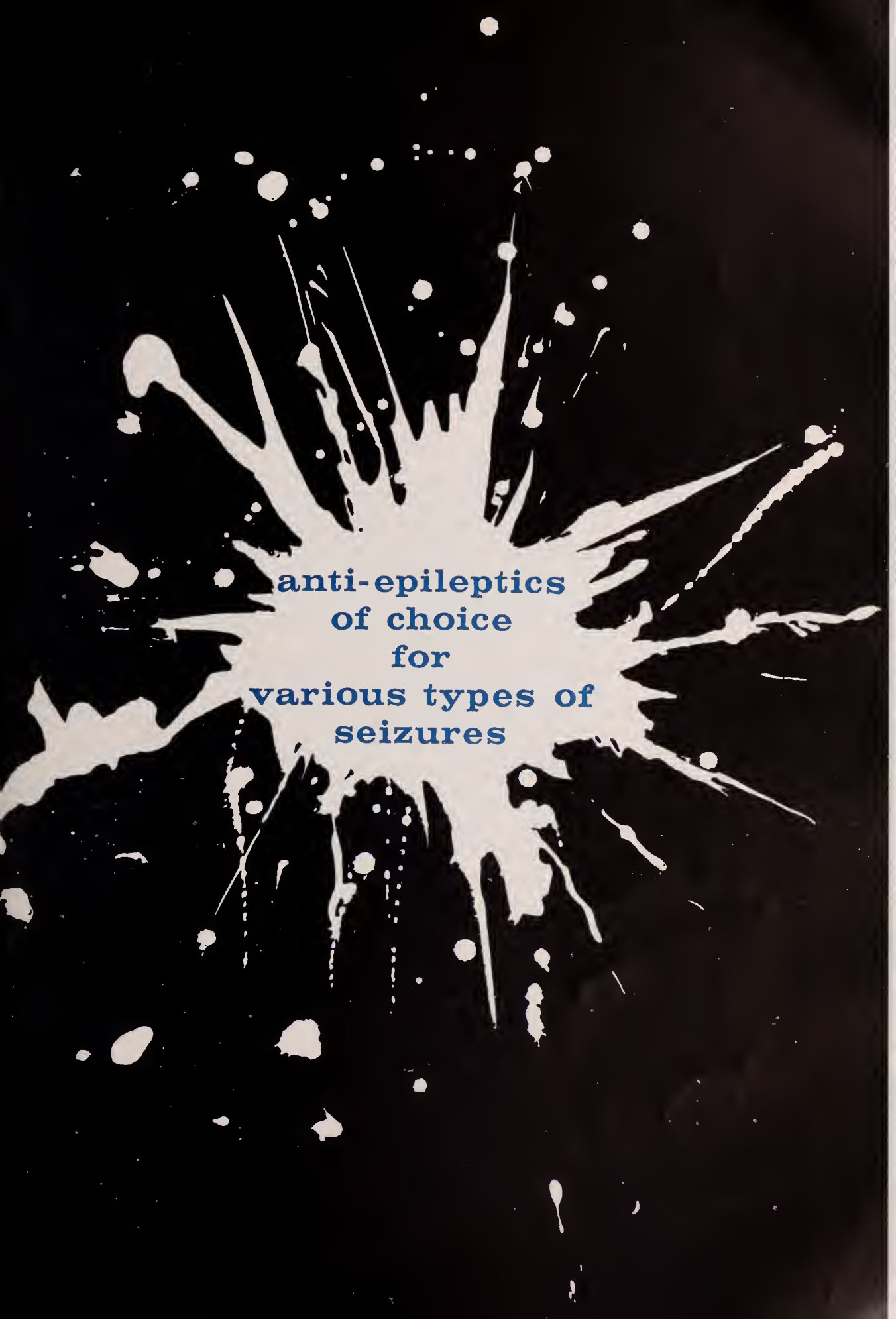
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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924



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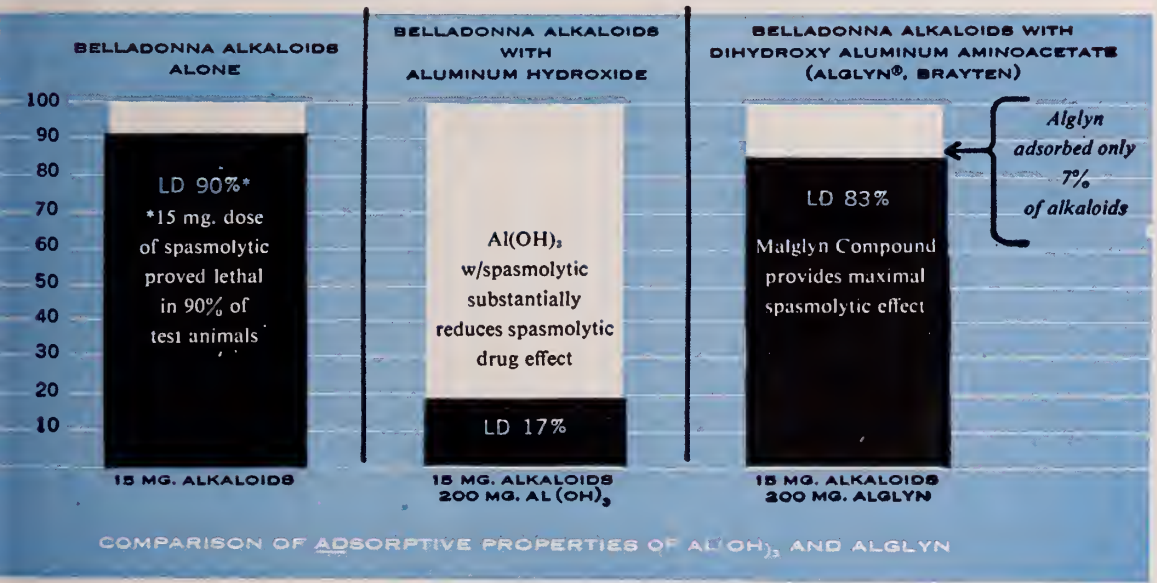
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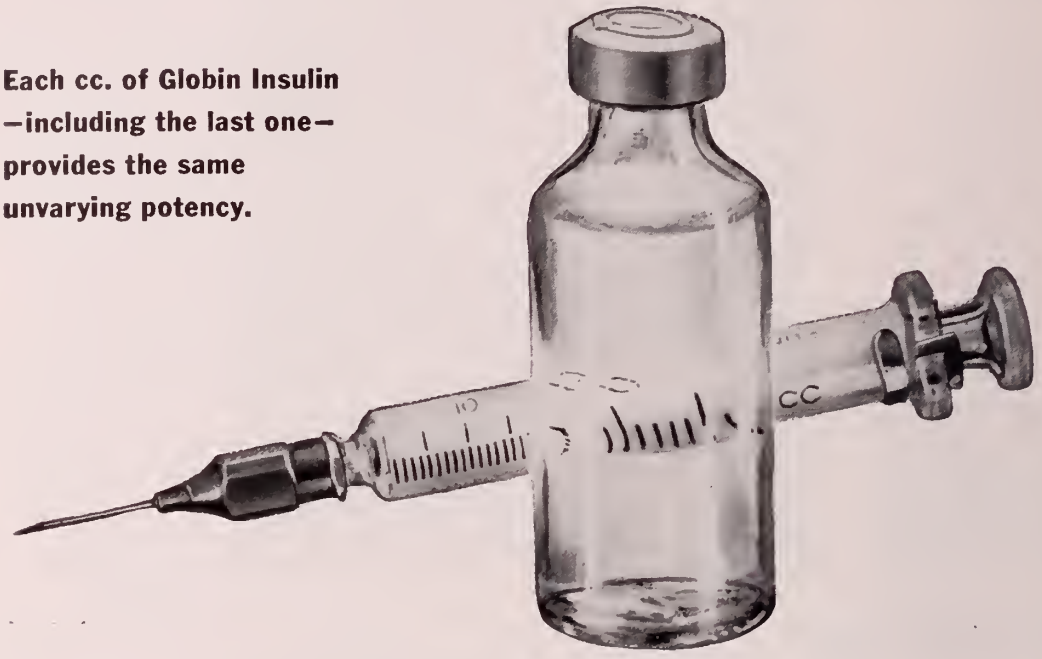
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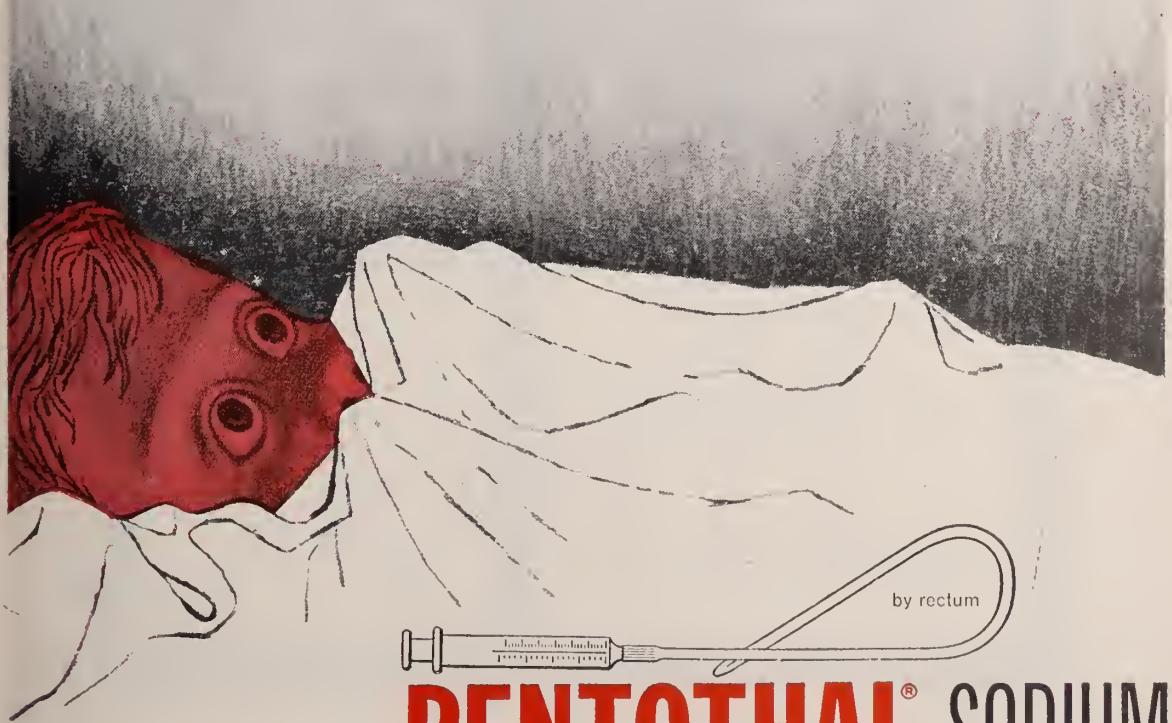
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1. Levy, S., *JAMA.*, 153:1260, 1953
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Progress in Cancer Control

JOHN R. HELLER, M.D.
BETHESDA, MD.

The importance of controlling cancer by every possible means is indicated by one fact alone: that is, that cancer is now the second leading cause of death in the United States. The advance of neoplastic diseases from eighth to second place among the leading causes of death since 1900 makes it a public health problem of national importance.

At the turn of the century when tuberculosis, pneumonia, diarrhea and other infectious and communicable diseases were taking their high toll of lives, 78,000 people a year were dying from cancer. There was but one specifically designated cancer hospital in America. There was no support from the federal government of programs for research or control and only one state recognized its responsibility in this respect. No word of cancer appeared in the media of public information. Nowhere was cancer a reportable disease.

Today, cancer is striking one in every four of our population and is the cause of one in every six deaths, taking an annual toll of more than 245,000 lives. Official agencies in all the states, the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands have cancer control programs. In the District of Columbia and more than half the states and territories, cancer has been made a reportable disease. Professional educational programs for public health workers, general practitioners, dentists, and nurses are under way. Intensive public educational campaigns are being carried on, and substantial improvements have been made in the treatment facilities and diagnostic services available to the individual citizen.

I make this brief comparison merely to show that in a short period of time—almost two generations, in fact—the rise of cancer has brought about a tremendous growth in the supporting elements which are necessary in a nationwide effort to control a disease of this magnitude.

Further, research of the past 10 years has remarkably expanded knowledge of carcinogenesis and of the diagnosis and treatment of cancer. As a consequence, both laymen and research investigators can now approach the problem of cancer and its curability from a more optimistic point of view. There is tremendous public concern about cancer and the necessity for bringing it under adequate control. Recently publicized data compiled by National Cancer Institute statisticians show that the annual number of persons in whom cancer is diagnosed is expected to increase from 530,000 in 1953 to 753,000 in 1975—unless cancer is bridled more extensively by control measures.

The National Cancer Institute, under the Public Health Service, Department of Health, Education, and Welfare, is charged with the responsibility for carrying out a comprehensive attack on the cancer problem. The Institute is supported by annual appropriations made by the Congress. The appropriation for fiscal year 1957, for instance, is $48,432,000. About one third of this amount is appropriated for research at the Institute. The remaining two thirds is appropriated for grants-in-aid to nonfederal institutions throughout the nation. A major portion of these grant-in-aid funds goes to support research, and the remainder is granted to states for use mainly at the local level to support activities in the control of cancer. It is through these local activities that the cancer program most directly reaches the individual citizen and aids the private physician.

Cancer control is concerned with the actual prevention of cancer whenever possible, with the discovery of the disease in its earliest stages, and

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Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 6, 1957.

with the provision of adequate services and facilities for diagnosis and treatment. To be effective, an ideal cancer control program requires: (1) an alert and trained medical profession; (2) an informed public; (3) suitable methods for prevention of the disease; (4) case-finding, screening, or diagnostic procedures which can be applied on a mass basis to sort out individuals with the disease from the remainder of the population; and (5) adequate services and facilities for diagnosis and treatment.

The control program of the National Cancer Institute is designed to meet some of the needs which exist in these requirements and to demonstrate appropriate methods for fulfilling some of these conditions.

Before discussing our control program in detail, however, I should like to show a few slides to emphasize the extent and nature of the cancer problem.

Cancer Assumes Increasing Importance As a Cause of Death

SLIDE 1.—This chart may help to explain why the Public Health Service was directed to enter this field. Here we see the position of cancer, in relation to other diseases as a cause of death. Following the red arrow, we see that cancer was in seventh place in 1900, in third place in 1925, and in second place in 1950. As we watch the decline of the infectious and communicable diseases, it is clear why medical and public health emphasis must shift to cancer and other chronic and degenerative diseases. Cancer has become a national health problem.

Cancer Death Rates for Selected Sites White Males 1914-1950

SLIDE 2.—This shows the trends between 1914 and 1950 in death rates for several leading types of cancer in white males. The mortality rate for stomach cancer has declined, but the mortality rate for lung cancer has gone up steadily and alarmingly.

Cancer Death Rates for Selected Sites White Females 1914-1950

SLIDE 3.—During the same period, the mortality rate for lung cancer in white females increased but not as markedly as in the males. Death rates for stomach and uterine cancer declined.

Parallel with the increase of cancer as a cause of death, there has been an astonishing increase in survival rates, especially for cases with reasonably early diagnosis and competent treatment. The gastrointestinal tract is the only major site for which our present knowledge and resources are not adequate to save the patient in at least half the cases. For some sites, we are already able to salvage the patient in considerably more than half. To bring survival rates closer to 100 per cent will require more knowledge, which, of course, is the object of research.

The National Cancer Institute's control program complements the extensive research programs under way. The steady growth of this program is a result of interest that public health agencies and other groups have taken in attempts to reduce mortality from cancer through early suspicion, accurate diagnosis, and effective treatment. The purpose is to translate findings of research investigations into clinical applications with the ultimate objective of reducing mortality from cancer. Toward this broad objective the program has two general aims: first, to find ways to shorten the dangerous time intervals between the onset of the disease and diagnosis, and between diagnosis and the start of treatment; and second, to improve the level of cancer diagnosis and management.

In the nine years our control activities have been in progress, a well rounded program of action has developed, both within the National Cancer Institute and through grants of funds to state health agencies, hospitals, medical schools, and other institutions.

State Cancer Control Programs

Grants for the support of cancer programs of the official state and territorial health agencies are made by the Institute directly to these agencies. These funds are granted on a formula basis which takes into account the size and density of the population, the number of cancer deaths, and the per capita income of the state or territory. The funds must be matched by state and local funds in the ratio of $1 for each $2 received from the government. The amount allotted to this program is about $2,250,000 annually.

More and more, the impetus for cancer control is coming from the states and local agencies and institutions. The national program is largely a reflection of these successful state and local programs that have pioneered in new directions. These programs have special implications for practicing physicians.

Since the cancer patient is usually seen first by the family doctor, his diagnostic training and experience often determine the outcome of the case.

It is important, therefore, that future doctors begin their practice of medicine equipped with the most recent knowledge in this field. Toward this end, the Institute administers a grant-in-aid program to assist medical schools in developing expanded and better integrated instruction in cancer.

Over $15,000,000 in training grants have been awarded to 83 medical, 42 dental, and six osteopathic schools since July 1947. Approved medical schools offering full four year instruction may receive up to $25,000 for a one year grant. Medical schools offering two years of work, and four year dental schools may receive up to $5,000 for a one year grant.

We have good reason to believe that this program is accomplishing its original objectives, which include: developing an awareness of cancer among medical students; improving the medical service to cancer patients, stimulating student interest in cancer research or control, and increasing the participation of the internist in cancer teaching.

Clinical Traineeships

The Institute has supported, since 1938, a program of postgraduate training for young practicing physicians. These trainees are placed in medical schools, hospitals, and training centers where suitable cancer teaching material, as well as qualified professional staffs, is available.

Since 1938, over 600 physicians have received support under this program. Consequently, the Institute staff believes that the program has been helpful in partially meeting the tremendous need for physicians trained in the various specialties vitally important to adequate management of the cancer case.

Research Training Grants

A new type of professional training grant was established by the Institute last year. Under this program, institutions receiving funds select and appoint the persons to be trained and determine the stipends they are to be paid. This program extends and supplements, but does not replace, the research training opportunities available through our regular research fellowships program.

Initial funds appropriated by the Congress for this program totalled $1,200,000, of which slightly more than half was earmarked especially for training in fields of chemotherapy and steroid hormones. The first grants recommended by the National Advisory Cancer Council represented research fields of cancer chemotherapy, steroid biochemistry, research medicine, pharmacology, biochemistry, immunology, research surgery, histochemistry, electron microscopy, genetics, cytology, radiobiology, and cancer biology.

Nursing Schools

Public health nurses and other registered nurses have come into cancer control to such an extent that much of the success of the control programs is shared by them. Five schools of nursing have received grants to support pilot studies for the development of better methods for teaching nurses about cancer.

Educational Aids

Among the many cancer educational aids for physicians in general practice is a series of six motion pictures which carry the over-all title of "Cancer—The Problem of Early Diagnosis." This professional series was produced jointly by the National Cancer Institute and the American Cancer Society. The first film in the series is a general orientation to the subject. The others deal separately with breast cancer, gastrointestinal cancer, uterine, oral, and lung cancer. An oral cancer exhibit and a set of projection slides showing oral cancer lesions are also available to dentists.

Public Educational Programs

Cancer educational programs for the public are carried on largely by such agencies as state and local health departments and state and local divisions of the American Cancer Society. We do contribute, however, to these programs by supplying educational materials and information of various kinds. Either alone, or in cooperation with other organizations, we have produced educational motion pictures, exhibits, and printed materials describing cancer of the various sites of the body.

Search for a Cancer Test

Cancer diagnosis at present depends on direct visual observation and identification of cancer cells either in removed tissues or in fluids collected from body orifices which communicate with the possible sites of cancer. If our present knowledge is to have completely effective application in the control of cancer, we must have a practicable case-finding method. The search for such a method is well under way and is directed along two lines—attempts at case finding by screening the general population by conventional clinical meth-

ods, and a program to find a suitable clinical test for cancer. By a suitable test we mean one which will be successful in identifying persons with cancer in an early localized stage, will not give false-positive results too often, and is simple and cheap enough for mass screening use.

The National Cancer Institute is supporting a variety of studies in this field. Through grants-in-aid we established in 1949 a program to determine the value of cancer diagnostic tests for case finding. This program is still being carried on at the five medical schools where it was begun. In addition, the Institute has supported studies at 10 universities and clinics to evaluate case-finding procedures.

Although the ideal serodiagnostic test has not been found, some advances have been made in other technics for the early discovery of cancer of specific sites. The most widely applicable and best developed of these is the cytologic test of Papanicolaou and Traut.

This test was first suggested by Papanicolaou as a diagnostic tool for detecting cancer some 30 years ago, and its use has become widespread only in the last 10 years. The method embodies the study of cells exfoliated from the surface of the epithelial lining of certain body organs. These cells are collected by aspiration and examined microscopically.

Uterine Cancer

The most significant and fruitful use of the cytologic technic has been in the diagnosis of uterine cervical cancer in its earliest stages. As a result of intensive study, the Public Health Service and other medical authorities believe that the uterine cervical lesion called intraepithelial carcinoma—or carcinoma "in situ"—is in fact cancer, and that the relatively long latent period between this stage and invasive cancer can be used to advantage in control programs. It is also believed that "in-situ" carcinoma is in reality early cancer and that invasive cancer is late cancer.

Memphis Cytology Survey

The most impressive results yet obtained in the early diagnosis of cervical cancer by the cytologic tests have been provided by a large scale study carried on in Memphis by the University of Tennessee College of Medicine, with the assistance of local medical societies, the National Cancer Institute, and other groups.

In this project, which was begun in 1952, vaginal cytology was applied in a mass screening survey for cervical cancer among 165,000 women 20 years of age and older who reside in Memphis and Shelby County.

This study produced a case-finding rate 40 times that observed in the community prior to establishment of the project. In addition to uncovering many unsuspected cancers, the study corroborated the observation that carcinoma-in-situ lasts long enough—several years, in fact—to permit effective curative treatment in practically 100 per cent of cases if discovered at the yearly check-up.

Results of Cytologic Screening

SLIDE 4.—This slide shows the highly encouraging findings obtained in the first 108,000 women tested. A total of 906 new cases of neoplasm was diagnosed. In the first screening 819 cases were found; of these 399 were intraepithelial, 346 invasive cancers of the cervix, 48 invasive cancers of the corpus, and 26 cancers of other organs, such as tubes and ovaries.

On the second screening 87 cancers were uncovered: 75 intraepithelial, nine invasive cervical cancers, two invasive cancers of the corpus, and one invasive cancer of another organ.

These findings indicate that cytologic screening has effectively reduced the case-finding rate for invasive carcinoma of the cervix from 434 per 100,000 in the first screening, to 43 per 100,000 in the second screening. One significant fact I should like to call to your attention is that the majority of these carcinomas were unsuspected either by the physician or the patient.

Age Distribution of Cervical Carcinoma

SLIDE 5.—These data are also based on the first 108,000 women tested. Here we see that the median age for intraepithelial lesions uncovered in the Memphis study was 36 years, while the median age of early invasive cancer was 51 years. This suggests that cancer of the cervix may exist for an interval of about 15 years in a noninvasive form when it is practically 100 per cent curable.

Since intraepithelial carcinoma presents no signs or symptoms, our alternative is clear: we must examine apparently healthy women at frequent intervals as a mean of eliminating or reducing cervical cancer mortality.

On the basis of this concept, and with additional funds made available by the Congress, the National Cancer Institute is now widening its studies of the cause, development, and course of uterine cervical cancer by establishing field pro-

jects in different parts of the country in cooperation with local health and medical authorities. Seven such research projects are now in operation and plans are under way to establish others. These projects will provide comparative data for the establishment of true incidence rates, and more information on the natural history of carcinoma-in-situ. They will also help to determine the relationship of carcinoma-in-situ to invasive cancer and the usual period of latency for this transformation, if it usually takes place. The Public Health Service believes that these additional projects represent positive steps toward the ultimate goal of totally eliminating this form of cancer as a health problem.

Variations of the cytologic method to aid in the diagnosis of cancer of other tissue sites are also under study. The usefulness of this technic is limited to symptomatic individuals because of the difficulty in obtaining and processing specimens for examination. Encouraging results, however, are being obtained with the cytologic examination of repeated sputum specimens in bronchogenic carcinoma. Also, in gastric carcinoma, recent developments have been reported for obtaining more representative specimens, such as the use of specific hormones and enzymes to obtain better specimens of exfoliated cells in greater numbers; the mechanical abrasion of the gastric mucosa with a balloon studded with silk threads; and the use of lavage solutions containing an enzyme to accomplish mucolysis.

An electronic device being tested will automatically search for and detect cancer cells in smears spread on microscope slides. This instrument—the cytoanalyzer—will enable the cytology technic to be more rapid and efficient in the screening of the population for certain types of cancer. This instrument classifies cells on the basis of certain optical values for size and density of the nucleus.

Field Research Projects

Field research projects—studies conducted directly by the Institute—have increased to where there are now over 60 such studies under way. These projects, conducted by our Field Investigations and Demonstrations Branch, seek to find causes, diagnostic procedures, effective therapy, and adequate methods for the control of cancer of all sites.

Epidemiologic Studies

We also have a number of epidemiologic investigations in operation, which provide much knowledge on the prevalence, incidence, distribution, and mortality of cancer in the population. Such data are essential to developing a means of controlling or preventing the disease. Typical of these studies are a project on the epidemiology of bronchogenic carcinoma in Pittsburgh; a study of childhood leukemias, lymphomas, and other malignant disease; and studies in geographic and racial distribution of cancer. Our project to gather data on smoking habits of World War I veterans, being carried out in cooperation with the Veterans Administration, is both a statistical analysis of available data and an etiologic study of the possible correlation between smoking and lung cancer.

Cancer Morbidity Surveys

Probably the most comprehensive undertaking of its kind ever attempted in the United States was our cancer morbidity study in which we surveyed 10 metropolitan areas in 1937. These same areas were resurveyed in 1947 to obtain current information and to determine what changes had taken place during the 10 year interval. The method used was to canvas all the diagnostic sources within a community—hospitals, clinics, laboratories, practicing physicians—and to obtain data on all persons coming for diagnosis or under treatment, so that an unduplicated count of persons ill with the disease might be made. At the time of the resurvey the population covered was 14,600,000, about 10 per cent of the total population of the United States.

These surveys have yielded much new information for evaluating the size and nature of the cancer problem. They indicate that, in the United States, cancer morbidity has increased even more than has cancer mortality.

The surveys indicate also that the magnitude of the cancer problem may be expected to continue to increase for years to come. The estimated annual increase in the number of persons in whom cancer is diagnosed, from 530,000 in 1953 to 753,000 in 1975, is based solely on two factors: the forecast increase in the number of persons in the United States, and the forecast increase in the proportion of older people in the population.

The first principle of cancer control—that early diagnosis offers the most hope for successful treatment—is borne out by data collected through follow-up of cancer patients in these surveys. Chances for survival in cases of cancer diagnosed while the lesion is localized at the site of origin

are much better than in cases in which the disease is diagnosed after the tumor has spread to adjacent tissues. In view of the demonstrated benefits of early diagnosis, it is unfortunate that in only half of cancer cases discovered today is the lesion being diagnosed while localized at the site of origin.

This record could be improved materially, because half of all cancers originate in organs or sites accessible to direct examination by the physician in his own office. This estimate excludes skin cancer. These sites are: the mouth and pharynx, thyroid, breast, skin, prostate, uterus, and rectum.

A comprehensive analysis of data from these surveys was published last year as Part I of a Public Health Service monograph. Part II of this publication is now in preparation.

Environmental Factors

Environmental cancer is an area of research in which we are most active. The different carcinogens that form a part of our environment are practically the only known causes of human cancer. For this reason public health and industrial groups are giving more and more attention to the investigation of suspected environmental cancerigenic hazards.

It is not surprising that most of the known carcinogenic agents have been found in industry, where workers suffer exposure to more agents, and in greater concentration, than the average person encounters in a nonindustrial environment. The growth of known exogenous causes, such as radiation, chemicals, and so forth, closely parallels the growth of those industries and professions in which cancerigenic agents are involved in services or industrial processes. The long latent period, however, ranging anywhere from one to 40 years, tends to hinder the recognition of causal relations between exposure to agents and the development of cancer. This delay occurs because many of the known environmental carcinogens are not particularly toxic and thus do not produce any striking symptoms. As injurious agents have made their appearance with the changing pattern of modern living, "environmental cancers" have developed among exposed people under different circumstances.

Environmental Cancer

SLIDE 6.—The work of Dr. W. C. Hueper and his associates in the field of environmental cancer has been extensive and outstanding. Here we see some of the results of their studies, showing the more important environmental carcinogens and the sites they attack in the body. Of the chemical agents, arsenicals cause cancer of the skin; processing of asbestos, chromium ores, and nickel may be associated with cancer of the respiratory tract; the carcinogenic substances in coal tar, pitch, soot, petroleum and shale oils, and crude paraffins are mostly of the types known as polycyclic hydrocarbons. These are complex molecules consisting of carbon and hydrogen, and they usually produce skin cancer.

Fumes of benzol, a chemical widely used in modern industrial processes, may affect the blood-forming tissues and lead to the development of leukemia.

A few aromatic amines—nitrogen-containing compounds—are included among the carcinogenic agents. Beta-naphthylamine, 4-aminodiphenyl, and benzidine have been associated with cancer of the urinary bladder occurring among workers in factories handling dyes and rubber antioxidants derived from coal tar products. Skin contact, inhalation, and ingestion are known to be the routes of exposure to these chemicals, but the manner in which they act is not yet known.

The carcinogenic physical agents are radiations of various kinds. The most important natural physical carcinogen is, of course, solar radiation. Cumulative exposure to solar radiation produces a relatively high incidence of skin cancer in sailors and farmers. Since it is believed that much of the effect of sunlight in producing skin cancer lies in the ultraviolet region of the spectrum, we suspect that ultraviolet light is an important causative agent for this type of cancer in man. The carcinogenic effect of ultraviolet radiation in laboratory animals has been confirmed.

X-rays, radium, and radioactive substances are other carcinogens in this class. They produce leukemia and cancer of the skin, bone, lung, and nasal cavities and sinuses. An example of the carcinogenicity of radium is the high incidence of leukemia among those survivors of the Hiroshima atom bomb attack who were within one mile of the center of the blast.

Preventive Measures

Industry is becoming increasingly aware of the challenge presented by environmental and occupational cancer hazards. Some industries have instituted preventive measures, such as the regular wearing of respirators and sealed clothing whenever exposure is likely; adequate ventilation as

well as the testing of certain industrial dusts which may be carcinogenic; periodic examination of the urine of dye industry workers; and protection against radioactive substances by shielding devices.

Treatment of Cancer

Since no real cure is as yet available for all cancers, physicians have defined the results of their treatment in the practical and understandable terms of years free from clinical evidence of the disease. It has become customary, therefore, to speak of "five year cures" and to make comparisons of one form of treatment with another form on the basis of results expressed in terms of five year cures.

Surgery and radiation still are the only effective technics for curative therapy. They are curative, however, only when the tumor cells have remained localized to areas from which they can all be removed by surgery or destroyed by radiation.

They have become more effective for cancer therapy because other scientific and medical advances have permitted them to be used more extensively. Better management of infections, hemorrhage, shock, anemia, faulty nutrition, and other secondary problems have made more extensive surgery practical. As a result of these improvements, the surgeon and the roentgenologist are now able to extend both curative and palliative surgery to tumors previously considered inoperable. The operative mortality rate has gone down, and the five year surgical cure rate for some types of cancer is improving.

In the last few years great advances have been made in knowledge of the relative sensitivity of different types of cancer. Radiation therapy has been improved by the development of accurate technics for the administration of predetermined doses of radiation to cancer-bearing tissue, whether by x-rays or radium. The armamentarium of the radiotherapist has been expanded from radium, radon, and medium voltage x-ray machines to supervoltage x-ray generators, and new types of powerful radiation, such as the cyclotron and betatron, and radioactive isotopes.

Supervoltage therapy now has an established place in the radiologic treatment of cancer, based on adequate clinical experiences gained during the last two decades. It, however, does not revolutionize the treatment of cancer patients. If used with proper adjustment of the technic to the physical peculiarities of the quality of radiation used, with clinical judgment, skill, well considered indications, and in particular with an understanding and appreciation of the risks, the higher voltages represent small but definite progress in the treatment of patients with certain types of cancer.

Let me stress, too, that supervoltage and megavoltage therapy have not made the use of medium voltage treatment obsolete. A larger machine is not always a better machine any more than a larger knife would be considered better for the operation of a cataract. In many situations, medium voltage therapy still has preference even when higher voltages are available.

A large part of research in the field of radiation is devoted to studies of the biologic effects of radiation in laboratory animals. Studies on radiation sickness are especially important. It has recently been found that injections of bone marrow into mice and guinea pigs exposed to a normally fatal dose of radiation can prevent or counteract many of the usual results of such exposure. It was also established that lead shielding of the spleen or certain other parts of the body increases the survival rate in animals exposed to high doses of radiation. These findings may prove valuable in radiation therapy of cancer, and in preventing radiation sickness or in counteracting its effects. Much remains to be learned in this area of cancer research.

It is estimated that one fourth of cancer patients who receive proper medical care are being cured today. The most optimistic estimates of results that could be obtained with the earliest application of surgery or radiation in all patients would perhaps double that figure. To save the remaining one half, we must look to the advance of future research.

Chemotherapy

Much emphasis is being put on chemotherapy, as this field offers probably the most promising approach to the treatment of disseminated cancer. The few therapeutic chemicals now available are not cures for any form of cancer. They have shown effectiveness, however, in temporarily halting the progress of certain cancers, alleviating pain, and rehabilitating the body in preoperative and postoperative stages to provide greater chance for survival.

The first evidence of a malignant tumor showing apparent suppression in patients by drug treatment was reported recently by National

Cancer Institute scientists. The cancer is choriocarcinoma, a rare tumor which occurs in the uterus after pregnancy. The drug used was methotrexate. This compound, developed in the last decade, has been successfully used to increase the survival time of children suffering from acute leukemia. In this study, four women patients with advanced choriocarcinoma were given methotrexate under an intense dosage regimen. Three patients showed suppression of cancer and disappearance of metastases for 12, 13, and 17 months, respectively. It is notable that metastases included secondary lesions in the lungs. The fourth woman's cancer, treated more recently than the others, was similarly suppressed.

True, this is a small number of patients. Nevertheless, it represents the first marked regression of a malignant solid tumor in patients by a drug.

Another new result reported recently was noted improvement, including a decrease in the size of metastatic lesions, in patients with acute leukemia treated with 6-Azauracil, an antimetabolite.

Similar promising results are appearing more and more in the literature. Already the list of compounds which have some place in the treatment of one or another type of metastatic cancer is long and includes estrogens, androgens, ACTH, cortisone, P^{32}, I^{131}, thiouracil, urethane, thioTEPA, TEM, nitrogen mustards, myleran, amethopterin, aminopterin, 6-mercaptopurine and azaserine. Each of these has shown palliative effects or some degree of remission against some type of cancer. Ultimately, however, the cancer becomes resistant to the drug. Nevertheless, much information is being accumulated on how these drugs work.

Interest in the chemotherapy of cancer has increased so much that it now ranks as one of the major areas of cancer research. The cure of cancer still remains with surgery and radiation, but in contrast to the dismal outlook of only a few years ago, chemotherapy is today regarded as a valuable adjunct to these methods.

Chemotherapy Cooperative Integrated Program

SLIDE 7. CANCER CHEMOTHERAPY INTEGRATED PROGRAM. — Research in the chemotherapy of cancer was expanded and intensified under a nationwide program begun in 1954 by the Committee on Cancer Chemotherapy of the National Advisory Cancer Council. Joint sponsors of the program are the National Cancer Institute, the American Cancer Society, the Damon Runyon Memorial Fund, the Food and Drug Administration, the Veterans Administration, and the Atomic Energy Commission. The impetus for this expansion was provided when the Congress increased support for research in chemotherapy in its appropriation to the National Cancer Institute for fiscal year 1954.

The program is guided by the Cancer Chemotherapy National Service Center, established and staffed by the sponsoring agencies and located at the National Cancer Institute in Bethesda, Md.

Essentially, there are two aspects to the program: the support of basic research throughout the country, by research grants, training grants, and fellowships; and the screening, pharmacologic work-up, and chemical evaluation of new drugs or drugs which have previously shown activity.

For the routine anticancer screening program, the pharmaceutical industry and university laboratories are furnishing at present some 25,000 chemicals and antibiotic filtrates annually to the Service Center. These materials are screened in one of six contract screening laboratories against three types of mouse cancer—Sarcoma 180, Carcinoma 755, and Leukemia L1210—especially chosen for their ability to indicate anticancer agents.

If a compound is found active, studies are made in animals of the blood and other body tissues and fluids to see what happens to the drug in the body. In addition, the proper dosage and any toxicity are determined before trial in humans is initiated.

If found safe, the agents are evaluated in volunteer patients, and the anticancer effects compared with one or more agents known to be active. In other studies such compounds are evaluated in conjunction with surgery and/or radiation. For these clinical trials nine cooperative study groups and two cooperative groups in the Veterans Administration have been formed representing more than 75 medical schools and hospitals located in different parts of the country. Analysis of data on end results is being accomplished through tumor registries set up to provide data annually on all types of cancer, and to undertake special studies on the effect of various treatments.

Research sponsored by the Center's grant program in the screening area covers the develop-

ment and evaluation of new compounds and of new screening technics, such as microbiologic methods, tissue culture, and human tumors in animal hosts, as well as the search for reliable biochemical technics for indicating the cancer-destroying properties of chemicals, hormones, and antibiotics.

Studies of a more fundamental nature, such as a search for biochemical differences, studies of mechanism of drug action, and studies of drug resistance, are being sponsored in the pharmacology area.

Contract work, in addition to the screening operation, concerns chemical synthesis, mouse breeding to insure an adequate supply of mice, the establishment of a mouse pox diagnostic laboratory, and hormone assay.

It is our sincere hope that this program will achieve its desired objective of accelerating the trial of promising anticancer compounds in human beings, when the safety and usefulness of the drugs have been established.

Although the subject is too broad for discussion here, I should like to mention briefly, for the sake of completeness, the postoperative rehabilitation of cancer patients. The serious psychologic and physical effects of mutilating operations, such as mastectomies, amputations, and radical head and neck surgery, make adequate rehabilitation of the cancer patient extremely important.

Many therapeutic procedures employed in this field are of such a radical nature that they cause manifold problems. Emotional and psychologic issues emerge which call for capable counseling as much as does the actual physical adjustment. Everyone coming in contact with the cancer patient —members of the hospital staff, the patient's family, his friends, and especially his employer and co-workers—must be educated to give encouragement and support to the cancer patient in his rehabilitation.

Aside from the frequent need to provide special appliances, such as colostomy irrigation sets, breast prostheses, and other similar devices, people working with the patient must appreciate the psychologic reactions to these aids. Some persons are able to accept such compromises and are grateful to science for providing substitutions which make possible continued activity and independence, both financial and personal. Other persons accept these appliances with feelings of defeat, frustration, and loss of status in their social group.

The size of the rehabilitation problem in surgical cancer patients can be gauged by the fact that, at Memorial Hospital in New York City, an average of 580 radical mastectomies is performed each year.

The number of patients with cancer of the larynx who have a total laryngectomy is in the thousands. The necessity for speech rehabilitation after this operation is now more widely recognized. Formerly it was believed essential only to operate and save a life. Now it is realized that the laryngectomy is just the beginning and that the restoration of speech must follow. The emotional and psychologic disturbances following this type of operation are considerable, sometimes requiring the aid of a psychiatrist, in addition to the all-important social worker. Nearly all of these patients can, however, by proper training in esophageal speech, resume their former occupations or other employment requiring the use of the voice.

The use of prosthetic appliances to restore cancer patients to normal appearance is increasing as more rehabilitation centers are established in the United States. This is especially true in the case of head and neck cancers, in which dentists play a highly important part in the constructing of facial prostheses.

Summary

To sum up, cancer control is a problem of integration, bringing current knowledge of the disease to the ultimate point of application—the cancer patient. Cancer control complements, but does not supplant, the extensive research programs now under way. Control measures cannot be separated from research. In fact, experience shows clearly that they are so closely related that for optimal results in either field they must be suitably integrated. Control methods, then, must continue to be applied to those points where research has opened another wedge of knowledge about the carcinogenic process in terms of diagnosis, treatment, and prevention. More and more knowledge, however small, is constantly becoming available for the prevention and control of cancer. Substantial headway in controlling the disease can be made if this knowledge is put to practical use.

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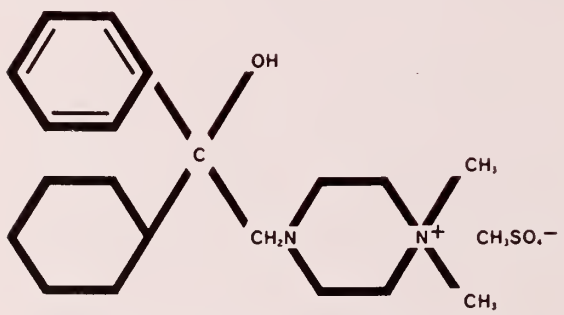
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A Brief Preliminary Report on a New Anticholinergic: Hexocyclium Methosulfate

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The ideal anticholinergic, one which would be effective in the gastrointestinal tract but free from side effects in other parts of the body, seems likely to remain just an ideal. Nevertheless, research has been developing anticholinergics which are more and more specific in their actions. One of the newest of such drugs is hexocyclium methosulfate, marketed under the trade name TRAL.*

Hexocyclium methosulfate is a quarternary ammonium salt with the following structural formula:



Pharmacologic studies have suggested that the postganglionic blocking action of hexocyclium methosulfate is more potent than that of atropine against gastric secretion in the histamine-treated rat and against the development of ulcers in the pylorus-ligated (Shay) rat. In the unanesthetized dog, hexocyclium methosulfate has an antimotility effect comparable to that of atropine, yet produces less tachycardia.

The specific pharmacodynamic action of hexocyclium methosulfate in animals implies the possibility of a similar action in the treatment of human gastrointestinal conditions. With the hope that this new anticholinergic would prove highly effective with a minimum of side effects, the present investigation was undertaken.

*TRAL (Hexocyclium Methosulfate, Abbott) for this study was provided by the manufacturer, Abbott Laboratories, North Chicago, Ill.

Procedure and Results

Hexocyclium methosulfate, 25 mg., was given four times a day to 22 patients with a variety of gastrointestinal conditions. All patients were on soft diets, all but one received antacids, and 12 were under sedation or tranquilization. Diagnoses and results obtained with this drug in the treatment of 10 cases of ulcer, seven cases of gastrointestinal inflammation, and five cases of miscellaneous gastrointestinal conditions are summarized in the accompanying table. No side effects were observed.

Diagnosis	Cases	Results			
		Excellent	Good	Fair	Poor
Duodenal ulcer	8	6		1	1
Pyloric ulcer	1	1			
Gastric ulcer	1	1			
Gastroenteritis	4		2	2	
Duodenitis	2	1	1		
Gastritis	1	1			
Hyperacidity	2		2		
Duodenal diverticulum and hiatus hernia	1	1			
Hiatus hernia	1		1		
Prolapsed gastric mucosa	1	1			
Totals	22	12	6	3	1

Conclusions

In 18 out of 22 cases of various gastrointestinal conditions, treatment with hexocyclium methosulfate, a new anticholinergic, was followed by good or excellent results, with no side effects. Such results warrant extensive further investigation of this new drug.

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Hazards in the Management of Peptic Ulcer With Anticholinergic Drugs A Re-Emphasis and Re-Evaluation

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The purpose of this report is to re-emphasize several infrequently considered complications of anticholinergic drug therapy in peptic ulcer that should be kept in mind prior to its administration on a routine basis. Specifically, these consist of complete pyloroduodenal obstruction, ileus, and unrecognized ulcer activity leading to subsequent perforation. This consideration is all the more important if a chronic partial obstruction has not been specifically excluded. Ileus can also ensue on such therapy in the presence of massive gastrointestinal bleeding due to causes other than ulcer. While it is admitted that these observations may be "nothing new," the frequency with which these complications recur and are not appreciated or recognized by internists, gastroenterologists and surgeons alike justifies this clinical report. A number of recent and pertinent concepts relating to the pharmacologic and the clinical aspects of anticholinergic therapy will also be alluded to briefly.

Complications in Unrecognized Pyloric Obstruction

In dealing with patients suffering from active peptic ulcer, I have been repeatedly impressed with the following train of events. The patient, varying in age from the second decade onward, had been complaining of moderate to severe long-standing ulcer pain. Although the pain retained its characteristic pattern of prompt relief by milk, foods and antacids at all times, it had recently become more frequent and troublesome. On no occasion did the patient experience nausea or vomiting. If vomiting had occurred, it was present on only one or two occasions sometime previously and had relieved the patient's distress temporarily. The attending physician would then often make the diagnosis of "intractable" ulcer pain and would forthwith order the necessary laboratory and gastrointestinal roentgen studies. In the interim, some modification of an acute ulcer regimen was instituted, consisting of an ulcer diet, antacids, sedation, limitation of activity, abolition of smoking, and nightly feedings. To this treatment would be added full doses of one of the more recently available powerful anticholinergic drugs, most notably methantheline (Banthine), propantheline (Pro-Banthine), mepiperphenidol (Darstine), or methscopolamine (Pamine). These agents were administered either orally or intramuscularly in an attempt "to stop acid production."

At this point, one of two complicated clinical courses occasionally ensued. Either the patient manifested complete pyloroduodenal obstruction clinically within several days or he became symptom-free. In the latter instance, the clinician found himself unexpectedly chagrined in the presence of his radiologic and surgical colleagues when the three to six hour roentgenogram of the stomach following barium ingestion revealed little or no emptying. Decompression would then be carried out with frequent aspirations, but usually to no avail, especially if the anticholinergic agents were inadvertently continued.

It is probable that the aforementioned sequence of events, which has confronted me at frequent intervals in the past several years, can be duplicated by most physicians dealing with the ulcer problem.[1,2] In fact, I have come to regard the seemingly clearcut condition of partial obstruction complicating benign prepyloric or duodenal ulcer as one of the more commonly misdiagnosed disorders of the gastrointestinal tract. One need only consult the hospital records of patients who have recently undergone surgery for obstructed ulcers to be made much more aware of the magnitude of this problem. Since this theme has been practically the same in nine patients with unrecognized obstruction who have personally come to my attention

Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 7, 1957.

within the last two years, I shall limit the brief case presentations to the following four.

Report of Cases

Case 1.—A 34 year old salesman had complained of recurrent epigastric distress for 10 years, radiating laterally and through to the back. It was cyclic, occurring with the stomach empty and during the night, and was always relieved immediately by either food, antacids or milk. One year previously, a duodenal ulcer had been noted on roentgenograms. There had been no obvious bleeding. The patient had only vomited on two occasions several months previously. Physical examination revealed a well developed and apparently well nourished white man. The abdomen was flat; neither significant tenderness nor a gastric succussion splash was elicited. A healed right inguinal herniorrhaphy incision and small external hemorrhoids were present. The complete blood count, sedimentation rate, urinalysis, liver studies, stool examinations, blood urea nitrogen, serum electrolytes, serologic determinations, serum amylase and chest roentgenogram were within normal limits.

Initially, an ulcer regimen was instituted, consisting of a bland diet, several nightly feedings, sedation, an antacid mixture, and oral Pro-Banthine, 30 mg. three times daily. There ensued a complete amelioration of the distress. The roentgen examination of the upper part of the gastrointestinal tract two days later unexpectedly revealed an almost complete retention of the barium in the stomach at four hours, with a markedly deformed duodenal cap. The cholecystogram demonstrated a normally functioning gallbladder without stones. After the anticholinergics were withdrawn, repeated fasting aspirations produced decreasing amounts of gastric volume from the initial one of 300 ml. to less than 50 ml. The ulcer program was continued for several weeks, during which time he remained completely asymptomatic. A repeat upper gastrointestinal series again showed poor emptying of the stomach with a stenosis at the duodenal cap, but at the end of four hours the stomach had now completely emptied. The patient refused surgical intervention and continued without further complication on the diet, feedings at night, antacids, complete abstinence from smoking and drinking, and no anticholinergic drug therapy when heard from last.

Case 2.—A 61 year old man, when seen for the first time, complained of epigastric symptoms since 1919. Except for becoming more frequent and requiring more medication, the distress had been essentially the same over the previous 30 years. It consisted primarily of a cyclic epigastric pain which did not radiate, occurring between meals and at bedtime, and frequently awakening him at night. Prompt relief was experienced from milk, food and antacids. He had been hospitalized in 1943, at which time roentgenograms revealed the presence of a duodenal ulcer. Repeat roentgenograms were taken which were interpreted as showing an old duodenal ulcer with a partial degree of stasis. On no occasion had there been evidence of bleeding, perforation or frank obstruction. Physical examination revealed a fairly well developed and well nourished white man in no acute distress, but who appeared to be chronically ill. The heart was slightly enlarged beyond the midclavicular line, and a grade II harsh aortic systolic murmur was present. The blood pressure was 200 systolic and 90 diastolic. The abdomen was not remarkable except for some sensitivity to pressure in the epigastrium; no attempt was made to elicit a succussion splash. The complete blood count, blood urea nitrogen, urinalysis, chest roentgenogram and electrocardiogram were not remarkable.

Treatment consisted of a first stage ulcer diet and nightly feedings at 1 a.m. and 4 a.m., along with an antacid mixture on the half hour during the day. He was also given Pro-Banthine intramuscularly thrice daily in doses of 15 mg. Two days later, a routine diagnostic gastric intubation yielded 1,000 ml. of gastric secretions. Accordingly, a modified feeding aspiration regimen was begun with the patient receiving 60 ml. of boiled milk on the hour during the day. Gastric aspirations were performed several times daily. He was also given parenteral intravenous fluids and electrolytes, including potassium chloride. On this regimen, complete obstruction continued for the next several days until the Pro-Banthine was discontinued, after which the gastric residue promptly decreased. He was subsequently subjected to an elective subtotal gastrectomy with a gastroenterostomy, at which time an almost complete duodenal stenosis was found.

Case 3.—A 62 year old bus driver was admitted to the hospital, his main difficulty consisting of recurrent, cyclic, nonradiating epigastric discomfort of approximately 15 years' duration. It frequently awakened him during the night. The distress had always been promptly relieved by the ingestion of milk. Roentgenograms taken 15 years and two years previously were interpreted as being consistent with a duodenal ulcer. There was no history at any time of vomiting or hemorrhage. During the previous two years, the discomfort had increased, but was still responsive to milk. Other complaints consisted of increasing generalized headaches, dizziness, lack of ambition and easy fatigability. During this time, he had lost approximately 20 pounds in weight. The past history was significant only in that he had experienced a perforated appendix approximately 40 years ago and three episodes of pneumonia.

Physical examination revealed a well developed but undernourished white man, who appeared to be somewhat depressed. Persistent rhonchi were audible throughout the left lower lung field. On the abdomen there was a ragged, healed incision in the right lower quadrant without herniation. There was some tenderness on firm palpation throughout the abdomen but no definite localization of the discomfort or a succussion splash. The complete blood count, sedimentation rate, urinalysis, serologic determinations, blood chemistry determinations and electrocardiogram were within normal limits. Examination of the gastric secretions revealed the presence of a considerable amount of free hydrochloric acid. A roentgenogram of the chest demonstrated the lung fields to be emphysematous. Only diverticulosis was noted on examination by barium enema.

It was the initial clinical impression on admission that the patient probably had a chronic duodenal ulcer without complication and was also experiencing an anxiety state with depression. A modified ulcer diet with an antacid between meals and at bedtime was prescribed. Several nightly feedings of milk were also given. Other medication consisted of oral Pro-Banthine, 15 mg. four times daily, and phenobarbital. An upper gastrointestinal series performed several days later revealed a complete obstruction in the region of the pylorus and duodenal cap. No emptying of the stomach was noted in the three hour roentgenogram. A modified feeding–aspiration regimen was accordingly instituted. Such a high degree of obstruction persisted, however, that within two weeks subtotal gastrectomy and gastroenterostomy were required.

Case 4.—A 52 year old broker was first seen in the office complaining of long-standing bloatedness, flatus and vague postprandial upper abdominal distress which had become more uncomfortable the previous several weeks. There was no vomiting or gastrointestinal bleeding. Intolerance for fatty foods had always been present. The patient had also recently been under considerable emotional duress. A duodenal ulcer had been demonstrated by roentgenogram two years previously. Physical examination revealed an obese white man in no acute distress. Aside from a slightly elevated diastolic pressure and some tenderness on firm pressure in the epigastrium, no significant findings were noted. A gastric succussion splash was definitely not present. The examination of the blood, urine, stools and chest roentgenogram was noncontributory. An electrocardiogram revealed a left ventricular strain pattern.

The patient was presumed to have a chronic pyloric or duodenal ulcer with an acute flareup and an added

anxiety state. In addition to the usual ulcer regimen, he was given elixir of Donnatal four times daily. At the time of an upper gastrointestinal roentgen study five days later, he volunteered that he felt "wonderful" and that all his distress had abated. An upper gastrointestinal series unexpectedly revealed an almost complete pyloric obstruction in the initial roentgenograms, but with complete emptying after three hours. Consequently, even though he exhibited the partial obstruction, it was elected to continue the same therapy in view of both his clinical response and the complete emptying of the stomach at three hours. Following one more asymptomatic week, however, he began to vomit, and a succussion splash was present. Gastric aspiration produced 1,100 ml. of fluid. A subsequent subtotal gastrectomy was required, at which time chronic duodenal scarring and an active ulcer at the pyloric ring were found.

Comment

The lesson to be learned and re-emphasized from these case presentations is that physicians should anticipate the presence of partial obstruction in every patient with chronic benign prepyloric, pyloric or duodenal ulcer who is experiencing more frequent and intense pain, whether nausea and vomiting are present or not. Although figures relating to its occurrence have been reported at considerably higher levels and are somewhat influenced by the type of clientele seen, an incidence of this complication of between 10 and 15 per cent of all ulcer cases seems to be generally accepted.

As was pointed out earlier, the clinical history may give little indication as to the presence of this complication. Persistent pain with but partial relief by food or antacids is often the only lead in the patient with long-standing ulcer. The past history of either a hemorrhage or a perforation is frequently obtained. It has been noted that not only may patients with obstruction not vomit, but patients not experiencing obstruction can do so most impressively.[2] When atypical pain and significant loss in weight dominate the clinical picture in the more acute "pyloric channel ulcer," this entity may be readily mistaken for psychic vomiting, carcinoma of the stomach, or gallbladder and pancreatic disease.[3]

In an admirable discussion of this subject, Ingelfinger and Sanchez[1] stressed the factor of unrecognized or ignored partial obstruction in the so-called intractable ulcer, and the neglect of the useful sign of "clapotage" (the gastric succussion splash) in making this diagnosis. It is pointed out that the amount of barium retained is not only an index of the pyloroduodenal stenosis but also of the gastric tone and motor power. Consequently, if the gastric tone is good and peristalsis is most active, there may be no significant fasting gastric residual volume.[1] Similarly, one may see no retention at three to six hours, even in the presence of a considerable degree of stenosis.[5,6] Bockus, Glassmire and Bank[5] found that in 77 cases with clinical and aspiration evidence of obstruction, radiographic evidence of retention at six hours was present in only 43 per cent. The determination of the free hydrochloric acid concentration of the gastric juice, both in the fasting state and after stimulation by histamine or insulin, is of no value in determining the presence of obstruction.

The hazard of intensive anticholinergic therapy with the induced postganglionic parasympathetic inhibition lies in the apparent fact that in such an instance the major effect of this treatment is to produce further paresis of the already distended and partially atonic gastric musculature. This has also been clearly demonstrated by Kramer.[7] The precipitation of complete obstruction was undoubtedly noted when belladonna and atropine were the only significant anticholinergics available. It was encountered less frequently, however, because of the more graduated doses, the greater stress on the limiting factor of side effects as the criterion of desired anticholinergic activity, and the availability of less potent and concentrated preparations.[8] Chapman and his colleagues[9-12] have made comparative studies of the effect of the oral administration of Banthine, in 100 mg. doses, and of tincture of belladonna, in doses of 0.4 and 0.6 ml., on the changes in propulsion, total contractions and tone of the upper portion of the intestinal tract by means of multiple balloon-kymograph recording methods. Banthine produced a striking decrease in propulsion and total contractions, along with a slight to moderate decrease in tone. The greater rapidity of this action and the greater inhibition of motility, as contrasted with tincture of belladonna in either dose, was pronounced. In essence, this has proved to be the observation of other investigators employing the same or other technics, and has been invoked as the most significant basis for the relief of pain by anticholinergic therapy.[13-15]

The important fact is often overlooked that even though most of these dynamic studies have been carried out on normal "control" subjects, diverse results are always encountered. These may consist of either no effect, delayed emptying, or an increased rate of gastric evacuation. Pathophysiologic experiments carried out in the presence of pyloroduodenal obstruction have shown

even more striking evidence of pharmacologically induced adverse effects on motility. In controlled radiologic studies, for example, profound degrees of retention were induced by either atropine, 0.6 mg. subcutaneously, Bellafoline, 0.5 mg. subcutaneously, or tincture of belladonna, 12 to 15 drops by mouth, administered 15 to 30 minutes before the barium swallow. This response occurred both in symptom-free patients with chronic stationary retention and in patients in whom decompression had previously been carried out.[7] It is fortunate that minor degrees of this inhibitory effect are probably counteracted by the stimulus of the meal-bulk itself.[9-12]

The current concept of the actual degree of anticholinergic effect desired in the treatment of peptic ulcer will probably have to be modified. It has been shown by various in vivo and in vitro studies, as in those dealing with chromodacryorrhea, that a specific anticholinergic effect can be elicited by very small amounts of the drug long before the muscular relaxing effects take place.[16] Obviously, one cannot accept the spasmolysis noted in the balloon-kymograph record as a measure of the desired therapeutic activity since this would be practically tantamount to considering as best that agent producing complete paralytic ileus. It is because of just such a possibility that anticholinergic drugs should be avoided both when surgery is shortly contemplated and in the immediate postoperative period.[17] Severe constipation is also apt to ensue.[18,19] Similarly, misleading radiographic appearances can be induced if they are administered just prior to the barium studies.

Concerning the acid inhibition produced by these agents, several observers have shown that a sizeable number of patients have but a slight decrease in acid output, even when other evidences of parasympathetic inhibition are striking.[20,21] Recent observations have denied the premise that the inhibitory effect upon gastric secretion and acid may be more important than the inhibition of gastric motility. In this regard, it has been demonstrated that in patients with pyloric obstruction, atropine inhibits the gastric emptying more effectively than the gastric secretion.[22]

The attitude towards the production of anacidity by drugs must also be modified by the demonstration that proteolytic neutralization cannot be considered complete if the pH of the gastric contents is less than five. Shay[23] clearly pointed out that the titration for free hydrochloric acid with Töpfer's reagent and phenolphthalein can be misleading. Outside of specially equipped centers, it is only by the direct measurement of the pH that one is usually able to detect low levels of gastric acid.[23,24] This superiority of the pH over the measurement of free acid units stems from the fact that for every one unit change in pH, there is a tenfold increase in hydrogen ion concentration. Most cases of "benign gastric ulcer with achlorhydria" have been so diagnosed on the basis of the added Töpfer's reagent remaining yellow. In reality, there is often ample free acid in these instances, but the pH may not drop below 4.0 or 4.5 because of the large amount of buffering mucus or serum exuding from the ulcer. It is also pointed out that since the expression "combined acid" has no clinical value whatever, both this term and the procedure should be discarded by clinicians.[24]

The therapeutic problem here being considered is paradoxically enhanced by the fact that many patients with partial obstruction are given anticholinergic drugs and are undoubtedly benefited by them, in large measure because of the promotion of ulcer healing by acid inhibition. Short of a therapeutic trial under close clinical observation, I know of no way in which it is possible to separate these patients from those in whom complete gastric atony will be produced. The patient gradation of the therapeutic dose of belladonna in previous decades has become somewhat of a lost art with the availability of the newer and more potent agents. In a study of the relative effectiveness of various anticholinergic drugs on basal gastric secretion, Sun, Shay and Ciminera[25] concluded that the proper dosage of these agents requires tailoring to the individual patient and that these amounts cannot be readily correlated with either body weight or any recommended uniform dose. It is fortunate indeed that most of the "antispasmodics" heretofore prescribed have not exhibited much significant pharmacologic activity.[26] This is becoming more of a problem, however, as improved technical means are being devised for producing sustained and high grade anticholinergic effects with the administration of as little as one delayed action preparation every 12 or 24 hours.

Complications In Gastrointestinal Hemorrhage

Less commonly a problem—but equally as significant—is the patient with massive hematemesis or melena from an undetermined site or of unknown etiology who is placed on anticho-

linergic drugs as a matter of routine. The rationale of this therapy usually pursues the following lines: Since most cases of gastrointestinal hemorrhage are statistically related to acid-pepsin-linked disease in the form of gastric ulcer, duodenal ulcer, gastritis or hiatus hernia with ulceration, vigorous antacid therapy may be beneficial. Consequently, since milk, cream and antacids merely neutralize preformed hydrochloric acid, the anticholinergics would seem to be preferred in order to "stop acid production."

Although this reasoning appears to be proper superficially, one must not lose sight of the fact that the blood itself functions as an effective antacid.[27] Furthermore, the patient is probably already experiencing partial ileus of a chemical, mechanical and reflex nature, related in large measure to the presence of blood in the gastrointestinal tract. Quigley, Bavor, Read and Brofman[28] have also shown that gastric atony is readily induced by emotional apprehension. It is recalled that at least 40 per cent of patients with active duodenal ulcer have some form of functional disorder involving the small and large intestine.[29]

It is apparent from these observations and from those relating to the effects of the anticholinergic drugs on gastrointestinal motility that if this type of therapy is vigorously administered in such a situation, profound ileus is apt to ensue. On the several occasions I have encountered this problem both in practice and in consultation, the patients had fortunately ceased bleeding and were readily compensated for their blood loss. Even so, a significant degree of added morbidity resulted. The history of three of these patients will be briefly presented, in one of whom (case 7) the induced ileus undoubtedly contributed to a fatal outcome. Gunn and Allen[30] reported five similar instances of paralytic ileus following the administration of either Banthine or Pro-Banthine during the treatment of gastrointestinal hemorrhage. In the presence of active hemorrhage, parenteral anticholinergics might even potentiate the degree of shock by interfering with the compensatory sympathetic activity as a result of the autonomic ganglionic block. A similar potential hazard exists in impending nonhemorrhagic shock, as might be encountered in the management of acute pancreatitis.

An additional pharmacologic observation referable to the anticholinergic effect of Demerol and the opiates is in order. With the use of the protection study technic, my colleagues and I[31,32] have previously evaluated the anticholinergic and antihistaminic activity of most of the therapeutic substances commonly employed for the relief of bronchospasm in asthmatic patients. Under these controlled and reproducible conditions, Demerol was studied in doses of 100 mg. intramuscularly. "Significant" protection was observed in five subjects against intravenous methacholine; this effect was observed for an average of 140 minutes. Others [33,34] have demonstrated the influence and untoward effects of the various opiates and related drugs upon gastric function. Accordingly, since most patients with hemorrhage from ulcer actually have but little pain and since morphine may actually deepen the degree of shock, the use of parenteral barbiturate preparations is to be preferred to the opiates in this condition.[35]

Report of Cases

Case 5.—A 27 year old man, whose illness had been previously diagnosed as moderately advanced, inactive pulmonary tuberculosis, was admitted to the hospital because of recurrent ulcer symptoms and persistent melena. No hematemesis had occurred. On previous occasions, sedation and antacid therapy had produced prompt relief of both the distress and the bleeding. Physical examination revealed a thin, pale, white man with epigastric tenderness and the presence of tarry stools in the rectum. The hemoglobin estimation was 10.1 Gm.; the hematocrit reading was 33 per cent. All examinations of sputum, both by smear and culture, for tubercle bacilli gave negative results. A large crater in the duodenal cap was seen. The small intestine and ileocecal area appeared normal.

The usual ulcer regimen was instituted with added Pro-Banthine in doses of 30 mg. intramuscularly, thrice daily. Shortly after the first injection, the patient began to complain of severe constipation, abdominal distention and difficulty in urinating. This state persisted for several days, even with the use of laxatives and decreased doses of the Pro-Banthine. He was profoundly distressed because of these symptoms, which he had previously experienced with similar therapy for the melena, but without the anticholinergic drugs. Following the discontinuance of this drug, his symptoms completely abated. Subsequently, a conservative program was continued, following which an elective and uneventful subtotal gastrectomy was performed.

Case 6.—A 54 year old policeman was admitted with a two day history of black stools. He had experienced infrequent epigastric distress since the diagnosis of a duodenal ulcer had been made radiographically 10 years previously. The only other pertinent aspects of his history were a chronic asthmatic bronchitis and external hemorrhoids. Physical examination revealed an obese, pale, middle-aged white man with moderate emphysema and some tenderness in the right upper quadrant of the abdomen. Large hemorrhoids and tarry stools were present. The hemoglobin and hematocrit values on admission were 10.1 Gm. and 32 per cent, respectively. An upper gastrointestinal series revealed an active duodenal ulcer.

In addition to the usual ulcer program, the patient received transfusions and was given subcutaneous injections of atropine around the clock. Although the bleeding subsequently ceased, he exhibited pronounced distention of the abdomen and required both enemas and

rectal tubes for relief. The parasympathomimetic drugs were avoided in view of the chronic asthmatic bronchitis. Shortly after discontinuing the anticholinergic medication in favor of hot water, small meals and parenteral fluids, the abdominal distress and distention subsided. The patient was subsequently discharged symptom-free.

Case 7.—A 64 year old salesman was admitted to St. Mary's Hospital for massive gastrointestinal hemorrhage of 18 hours' duration. This was manifested by massive tarry stools, hematemesis, and loss of consciousness when he attempted to get out of bed. He had previously had a bleeding peptic ulcer 20 years before. His condition was also complicated by the fact that he was a long-standing diabetic patient who refused to take insulin. Furthermore, he had apparently been in mild heart failure for the previous five months as evidenced by dyspnea on exertion, but without pain. He was a well developed, somewhat overweight man appearing markedly pale. The pulse rate was 104 and regular. The blood pressure was 174 systolic and 80 diastolic. There was moderate angiosclerosis of the fundal arterioles. He had dislocated several teeth as a result of falling while attempting to get up. Examination of the heart, lungs, and abdomen was not remarkable.

The patient was immediately given transfusions, along with milk and antacids orally in small amounts. The blood sugar was 518 mg. per hundred cubic centimeters on admission. Small doses of regular insulin proved to be most effective in controlling the diabetes. An electrocardiogram revealed extensive depression of the ST segments, indicative of active currents of injury; a tachycardia was also present. With repeated transfusions, he appeared to be holding his own over the next two days. The pulse was regular at a rate of approximately 96 per minute. The level of the hemoglobin stabilized at 9.4 Gm. and the hematocrit value at 31 per cent. The fourth blood sugar determination was 94 mg.

A surgical colleague then saw the patient in consultation because of the possible necessity for surgical intervention, notwithstanding the extremely precarious medical state. In addition to the procedures named, it was recommended that he be given Pro-Banthine, 15 mg. every six hours. Two hours after the first dose, ileus of considerable degree and tachycardia with a pulse rate of 140 to 160 per minute were present. Complete urinary retention ensued, with 950 ml. of urine being subsequently obtained by catheter. Rapid digitalization was promptly instituted over the next several hours. No further gastrointestinal bleeding was apparent. In spite of these efforts, acute pulmonary edema developed, and the patient died several hours thereafter.

Other Potential Hazards

Anticholinergic drugs should be regarded as an adjunct to, but never as a replacement for, the dietary-antacid-physical and mental rest programs which have been time-proved in promoting ulcer healing. The premature liberalization of such regimens that is based solely on the subsidence of pain can be fraught with danger, particularly that of perforation. The same admonition applies to the alteration of the patient's previous symptom complex when "interval" anticholinergic therapy is maintained, leading to a false sense of security.[36] This issue is especially important if the patient is not aware of the fact that ulcer recurrence cannot be positively prevented by such therapy. The physician is reminded of the fact that these drugs interfere only with the vagal phase of gastric secretion, but not the gastric or intestinal hormonal phases. If considerable pain persists after several days of a regimen combining stomach rest and anticholinergic drugs, the probability of a confined perforation or a deep penetration looms large.[36]

The use of these drugs is advised with caution in the presence of heart failure or coronary insufficiency because of the tachycardia that is frequently induced, as occurred in case 7. In addition to this effect, it is not generally appreciated that a profound postural hypotension may ensue following full atropinization. This has been recently demonstrated in a large group of normal adult males by Kalser, Frye and Gordon.[37] The parenteral route of anticholinergic administration, in particular, is fraught with the danger of inducing myocardial ischemia.[38]

Finally, to complete the spectrum of the possible hazards of intensive anticholinergic therapy, brief mention is made of the several others that are commonly encountered. Xerostomia and impaired visual accommodation occur most frequently. The former is not as benign a complication in some patients as one might believe; it can, in fact, cause considerable difficulty in the preoperative management of certain patients. Because of the potential increase in the intraocular pressure, these drugs are generally contraindicated in the presence of known glaucoma and should be used cautiously in the aged. Symptoms of urinary retention are frequent in full doses, even in young men who have no obvious prostatic obstruction, as occurred in case 5. Drowsiness, headaches and abnormal behavioral manifestations suggesting central nervous system stimulation have been reported.[39] I have witnessed the "alert reaction" following the use of many therapeutic agents and have come to expect its occasional occurrence from practically any effective drug, including the sedatives and tranquilizers. Drug rashes and other idiosyncratic reactions have also been noted. In view of the disruption of the esophageal parasympathetic innervation, the anticholinergics are contraindicated in the presence of cardiospasm.[40] A curare-like reaction to oral methantheline has been observed to result from the blocking of the nicotinic effect of acetylcholine, as manifested by asthenia, muscle flaccidity, are flexia and coma.[41]

Summary

Anticholinergic drug therapy should not be instituted in the routine management of the pa-

tient with peptic ulcer unless the presence of chronic pyloroduodenal obstruction has been specifically ruled out. Several important observations and pitfalls relating to the diagnosis of partial pyloroduodenal obstruction are emphasized.

Anticholinergic drugs should be used most cautiously in the initial management of patients with significant gastrointestinal hemorrhage.

Clinicians must be aware of the fact that a high degree of anticholinergic activity during the "interval" phase of ulcer therapy might alter the patient's symptom complex to an unrecognized recurrence and lead to further complications, particularly perforation.

The pathophysiologic and pharmacologic considerations relating to the observed adverse side effects are cited and discussed.

The practicing physician is urged to maintain a constant appreciation of the significant side effects of these potent drugs which he frequently employs. He should avoid using them ritualistically and still maintain his reliance on the time-proved staples of ulcer therapy.

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Discussion

Dr. Winston K. Shorey, Miami: This comprehensive and well documented paper certainly leaves little for a discussant to add regarding the difficulties a physician may encounter when using anticholinergic drugs in the treatment of peptic ulcer. I heartily congratulate Dr. Roberts for bringing to us this timely reminder that in our therapy of ulcer we must not proceed under the illusion that anticholinergic drugs have provided a real answer to this disease.

To emphasize further that one must expect a high frequency of gastric retention when these drugs are given to patients with partial pyloric obstruction, I would point out that significant gastric retention occurred under the influence of anticholinergic drugs in 50 per cent of patients who had no reported evidence of pyloric obstruction in a study conducted by Texter and his associates.

In regard to the matter of precipitating a complete obstruction by administrating an anticholinergic drug to a patient with partial obstruction, I have a comment

and a question. As Dr. Roberts has already pointed out, a patient may have a considerable degree of pyloric stenosis and yet not have significant gastric retention as long as the stomach retains sufficient muscular ability to drive its content through the narrowed outlet. If we then depress gastric motility with an anticholinergic drug, gastric retention occurs, and may be complete. In doing so, however, we have not changed the actual degree of organic obstruction at the pylorus. To be sure, a high grade organic pyloric stenosis may be first recognized when the patient receives an anticholinergic drug, as vividly demonstrated by cases presented by Dr. Roberts today. Nevertheless, in other cases there may appear to be pronounced organic stenosis when actually muscle atony is the major problem. My question to Dr. Roberts is, "If a patient with partial obstruction is given an anticholinergic drug, does not the greatest hazard lie in the possibility that the degree of organic obstruction will appear greater than it actually is and thereby result in the committing of a patient to surgery when it is not really necessary?"

I certainly agree with the essayist regarding the undesirability of administering these drugs to patients with bleeding ulcer. The presence of glaucoma and an obstructing lesion at the outlet of the urinary bladder are unquestionably contraindications to their use.

The hazard which in my opinion is the greatest of all has been adequately discussed by Dr. Roberts, and I have already referred to it myself. That is the placing of reliance upon these drugs to cure peptic ulcer to the extent that the time-honored therapeutic measures used in the treatment of this disease are not adequately administered. Evidence is developing to substantiate the belief that these drugs cannot be relied upon to alter the long term course of peptic ulcer. Complications may occur during their administration even though the patient is symptomatically improved.

DR. ROBERTS, closing: You are correct in pointing out that a major discrepancy between the clinical picture and the radiographic obstruction may occur while these patients are kept on anticholinergic therapy. I try, of course, not to use these drugs until proper roentgen studies are made. If the patient has been receiving anticholinergic therapy, I usually request discontinuance of the treatment for at least several days prior to the roentgen studies of the stomach. When there is doubt, as is always the case with laboratory procedures, the roentgenograms should be repeated. Dr. Shorey has again properly re-emphasized the potentially misleading roentgenograms of the stomach in pyloroduodenal stenosis wherein they may not show any overt obstruction when it is present if the gastric tone persists. Now what has happened in these patients by administering anticholinergic drugs in the presence of partial obstruction has merely been in most instances to precipitate gastric decompensation more readily, making surgical intervention truly mandatory. I have no time to go into the whole philosophy of anticholinergic drug therapy as related to the management of ulcer. Suffice it to say that I honestly believe we may have to revise our concept of the degree of anticholinergic therapy usually required in these patients, both as a result of clinical and in vivo and in vitro studies. I personally regard it as unwise to push these drugs too much in most patients with ulcer.

Thank you once again, Dr. Shorey, for your kindness in discussing this paper.

Neglected Phase of Management Of Bronchial Asthma

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Experience with asthmatic patients in the allergy clinic and private practice indicates that the single most effective weapon in the management of these patients is the one usually overlooked. Asthmatic patients armed with a battery of proprietary drugs, puffing on nebulizers, and starved on rigid elimination diets still come seeking help. A few have been treated with steroids and a few have had allergy surveys and hyposensitization. Practically none, however, know about the causes of their trouble and how to avoid them.

This ignorance among patients is no doubt a reflection of the inertia of the physicians who advise them. The tragedy is that the concept of the management of the asthmatic patient should differ but little from the concept of the management of the patient with poison ivy dermatitis or ragweed hayfever. Few physicians will not agree that the best treatment for poison ivy dermatitis is not to walk in the poison ivy. Few will not agree that the best treatment for ragweed hayfever is to spend the hayfever season in a pollen-free section of the country or in an air-conditioned home. While it is true that Rhus hyposensitization and ragweed hyposensitization give protection if exposure should occur, by far the best relief is obtained by the patient who is not exposed at all.

This method of treatment is available to the family physician as well as to the allergist. It should be the responsibility of the family physician to institute elimination measures and to educate his patients even before he refers them for allergic diagnostic surveys. Also, it should be the responsibility of the family physician to follow up his instructions with home inspection visits after hyposensitization has begun.

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Why then should it be so difficult for physicians to educate patients with bronchial asthma in the ways and means of reducing exposure to causative factors? After all, asthma is the same allergic reaction and has the same physiologic and pathologic basis as Rhus dermatitis and ragweed hayfever. The difficulty arises because the factors involved in the production of asthma are often multiple while the factors in dermatitis and hayfever are easily demonstrable and individual in nature.

Even though there may be multiple factors involved in the production of asthma, these factors are well known, and the means of avoiding them are at hand. Only the inertia of physicians and the ignorance of patients prevent the widespread adoption of preventive measures.

Allergens in the Home

It is exposure to causative agents commonly found in the home that causes trouble for the asthmatic patient. Most of the troublemakers are traditionally found in the home and are not necessities at all. Most are decorative, and few are utilitarian. Many add nothing to the joy of living. In most instances they may be disposed of with ease. Few of them will ever be missed.

Perhaps the worst single offender is house dust. If it were possible to remove the source of house dust and to eliminate the places where it gathers, asthmatic patients would be improved. It is obviously easy to accomplish both objectives and avoid tragic results. House dust comes from within the home and is made up of deterioration products of feathers, cotton, wool and kapok, as well as molds, and various animal hairs.

Nothing could be more simple than to remove from the home of the asthmatic patient all of these substances. Feathers will be found in pillows. Foam rubber pillows are easily substituted. Feathers are also found in comforters. Woven cotton blankets may be used. Feathers may be found in sofas and cushions. Foam rubber may be substituted. This change may entail some expense in the refurbishing of the sofa, but the money is better spent on the sofa than on epinephrine.

In the same manner cotton quilts and mattresses must be eliminated. Cotton fiber is not allergenic, but it is the poor unrefined grade of cotton used in stuffing quilts and furniture that contains the cottonseed. It is the cottonseed, in all probability, that helps incite the asthma.

Wool is no more of a problem than cotton. Nylon blankets and rayon or nylon rugs are more than adequate substitutes for wool. Nylon or dacron clothing in many ways is superior to wool, and certainly the former is harmless for the asthmatic patient.

Kapok is known commonly as silk floss. It is widely used in stuffing pillows, mattresses, furniture and cushions. It rapidly becomes infested with molds and rapidly crumbles to dust. In this moldy, dusty state it becomes a powerful allergen. Foam rubber may be substituted for kapok in any pillow, mattress, or piece of furniture.

Here then are four substances that may be banished from the environment of the asthmatic patient. No community effort is necessary. Contrast the simplicity of throwing away an old sofa with the difficulty involved in spraying all patches of poison ivy or ragweed in a city, and it should be obvious that the asthmatic patient is in a good position to do something about the control of his environment.

The patient with asthma can also eliminate the places where dust might settle. He may design his home so that removal of dust, like the removal of garbage in a disposal unit, is facilitated. This means he will have no drapes framing his windows in great dusty cloths. He might have easily dusted blinds or even opaque glass in the window so that one wipe of a damp cloth daily disposes of window dust. He will have only essential carpeting. His floors should be bare so that the wipe of a damp mop will remove all the floor dust quickly and easily. Bare floors are not unattractive. Cork, asphalt tile, parquet, and terrazo are all utilitarian and attractive. None require carpeting. The asthmatic patient requires no bedspread. This seldom-laundered dust collector deposits dust right where he will spend the longest part of his life—in his bed. The asthmatic patient needs less wall décor, fewer plants, and less litter on his bureau tops. He should have a smaller collection of books and magazines. All of these articles collect dust, or dust settles on them, and all need to be dusted. They all hide dust in pockets and crevices, and the patient with asthma needs his dust in the open where he can fight it with damp cloths.

After the dust has been mastered, he can turn his attention to the molds. In eliminating dust, he will have partially solved his problem with mold, but much remains. Unfortunately, many mold spores are blown in from the out-of-doors as are pollen grains. It is probable, however, that most of the molds that participate in the produc-

tion of asthma come from within the home. They grow luxuriantly on discarded shoes which lie neglected at the bottom of a closet. They grow on unused luggage, on cardboard boxes storing old mementos. They grow on old books and magazines, and they grow on record albums. They thrive in junk-laden closets and in damp basements as well as in souvenir-crammed attics.

The solution for the asthmatic patient lies in breaking with sentiment. Cherished but moldy souvenirs must go. Either they are consigned to the trash, or they are demolded at regular intervals. Nothing defeats the growth of mold so well as light, air and dryness, and all closets in the home of the asthmatic patient must have these in abundance.

With the departure of the dust and mold, the battle is nearly won. Only incidentals remain. Beneath the rug, for instance, will probably be found a rug cushion or pad. This is carefully compounded from horse and hog hair, both potential troublemakers. Much of the furniture will have horse hair in it. Much of the upholstery will be mohair, which is goat hair. Children's toys will be made soft and cuddly with a potential offender, rabbit hair. Rabbit hair will also be found masquerading as expensive furs. Cattle hair will be found in rug cushions and in carpets. The more of these incidentals that can be tracked down and eliminated the better will the asthmatic patient feel.

The most difficult sales job still lies ahead. I have yet to see the asthmatic patient who could believe that his adoring Fido or Tabby could play a part in making asthma worse. Nevertheless, dog hair and cat hair are powerful allergens, and the patient with asthma should have fish, turtles, or lizards for pets. While fewer human characteristics can be attributed to them, they are generally less of a menace.

Since the asthmatic patient will spend about eight hours of each day, one third of the day, in his bedroom, it follows that the bedroom is the room which must be most spic and span. The rest of the house must not be neglected, but if the bedroom is above criticism, symptoms will generally improve. The more severe the asthma, the more important it is to enforce all precautions strictly in all parts of the home.

Once the debris has been removed, the roles of diet, infection and emotion will become more apparent. When inhalant factors are at a minimum, the effect of diet manipulation is more readily apparent. When inhalant factors are removed, the asthmatic patient can often withstand remarkably well the infections which previously precipitated an attack of asthma.

As far as emotional factors are concerned, it will be noted that emotional upset is tolerated better just as are the infections. I believe that the prompt relief which many asthmatic patients find in the hospital is not related to removal from an emotion-charged home environment. It is rather due to their sudden removal from the autogenous house dust, molds and incidentals. Almost all hospitals are equipped with signs reading "Floor Wet," which are used daily, and most larger hospitals are equipped with machines for washing walls. Most hospitals have no carpeting, and few have bedspreads, drapes, or storage in the closets. It is for this reason that the patients improve in the hospital without other therapy.

The place for hyposensitization is as a supplement to elimination. The resistance of the patient can be increased to allergens which he cannot avoid. He can be helped to develop resistance to avoidable materials in case he should be unavoidably exposed. Hyposensitization may be, as many physicians and patients believe, a magic process which can transform an asthmatic patient from a sick to a well person, but hyposensitization without elimination is like prescribing glasses for a man with no eyes.

Summary

In summary, the allergens which are potential sources of trouble to an asthmatic patient are well known. Elimination of these allergens from his home, and particularly from his bedroom, is the most important phase in the management of the patient with asthma, and is the most neglected aspect of management. Diet manipulation, control of infection and psychotherapy are important aspects of management, but without elimination they will not yield much relief. Hyposensitization is important as a supplement to elimination.

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The Treatment of Cardiac Arrhythmias By Drugs

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The most common type of cardiac arrhythmia is the normal physiologic phenomenom of phasic speeding and slowing of the heart rate, usually, though not always, dependent upon the respiratory phase. It is a functional condition which never requires treatment. All other arrhythmias, even when occurring in normal hearts, may at times require drug therapy, a résumé of which follows.

Premature Beats

1. Auricular
2. Ventricular

Premature beats demand treatment when they precede attacks of paroxysmal tachycardia, when they occur during operative performances, and when they appear after coronary occlusion.

When it can be found, the cause should be remedied or removed, as in the case of digitalis poisoning, hyperthyroidism, and extrinsic irritants such as tobacco, coffee, tea and alcohol. Occasionally the intake of a particular food is followed by premature beats and other arrhythmias. This has been noted to occur after fatty meals, and there is now some evidence to suggest that postprandial lipemia has an irritating effect on an abnormally sensitive myocardium.[1] Aside from specific therapy which may be indicated by the cause, symptoms often can be relieved by reassurance and simple sedation, as by phenobarbital. Sometimes a period of rest and relaxation, a vacation with its freedom from the usual responsibilities and tensions, is sufficient to abolish premature beats. It is of some value to know whether the premature beats arise in the atria or from the ventricular musculature since certain drugs are more effective in the treatment of ventricular premature beats than in other varieties.

Quinidine sulfate may be successful in abolishing premature beats of any type. The amount required, as with all drugs, varies with the individual, but it is seldom that more than 0.2 Gm. every three to four hours is required for this purpose.

Digitalis itself is sometimes useful in the prophylaxis of premature beats, but when it is clear that ventricular premature beats are due to digitalis, then potassium, such as the acetate, 2 to 4 Gm. (30 to 60 grains) every four to six hours is usually of benefit. Even when digitalis is not a factor, the addition of potassium to the other therapy is of value sometimes.

Supraventricular Tachycardia

1. Sinus
2. Auricular (atrial)
3. Nodal
4. Auricular (atrial) flutter
5. Auricular (atrial) fibrillation

Sinus, Atrial and Nodal Tachycardia.—The statements made regarding causes and treatment of premature beats are applicable to paroxysmal atrial and nodal tachycardia, and occasionally to sinus tachycardia; in addition, vagal stimulation often abolishes attacks of paroxysmal tachycardia. The vagi may be stimulated by pressure and massage on the carotid sinus with the patient preferably in the prone position and with the head turned from the side which is to be stimulated, especially the right side, which has been found to be more sensitive. Other maneuvers such as pressure on the eyeballs, holding the breath and lowering the head sometimes serve the same purpose.

There are many drugs which have been used successfully for the abolishment and prophylaxis of tachycardia. One of these, which seems not to have been widely used but which is effective, is neostigmine (Prostigmine). This drug is thought to inhibit cholinesterase, which destroys the acetylcholine liberated at the vagal ends, thus encouraging the vagus inhibiting effect. There is some evidence to suggest that it is more effective in patients who have been digitalized. This drug, given by vein in a dose of from 0.125 mg. to 0.25 mg. every 20 to 30 minutes, will usually be effective after one or two doses.

Digitalis by vein is often sufficient. The preparation which has a great reputation for this use is lanatoside C (Cedilanid) in a dose somewhat less than the average digitalizing amount. Any injectable digitalis may be used.

Procaine amide hydrochloride (Pronestyl) is a valuable drug, but has the disadvantage when given by vein of producing, sometimes, pronounced hypotension. When this drug is used by vein, it is well to inject it slowly at a rate that will introduce 100 mg. every few minutes with careful observation of the blood pressure. The dosage when given by mouth varies from 250 mg. to 500 mg. every three to six hours.

Neo-Synephrine may be effective by vein in doses of 0.5 mg. Its use is often accompanied by a rise in blood pressure which seems to be due to the drug effect on the carotid sinus reflex. It is said to be contraindicated in patients with ventricular premature beats.

Acetyl beta methylcholine (Mecholyl) is highly effective, but produces such alarming concomitant effects that its use should be restricted to those cases in which all other measures have failed. It is given subcutaneously, in 20 mg. dosage which may be repeated in 30 minutes. It produces salivation, diarrhea, precordial pain and bronchial spasm. Atropine sulfate, 1 to 2 mg., will relieve the symptoms produced by Mecholyl and should always be on hand.

Acetylcholine is another parasympathomimetic drug which is effective sometimes when given by vein in a dose of 50 to 100 mg.

Methoxamine hydrochloride (Vasoxyl) in 10 mg. dosage by slow intravenous injection is frequently useful, but on account of its pronounced pressor action should be used with great caution in patients who have hypertension, cardiovascular disease or hyperthyroidism. Other pressor drugs may be tried with similar precautions.

Levarterenol (Levophed) has been used successfully in the treatment of paroxysmal supraventricular tachycardia in patients in whom hypotension and shock developed.[2] The drug was given by vein in a concentration of 8 to 16 mg. per 1,000 cc. of 5 per cent glucose in water, at a rate of 20 to 30 drops per minute. The rate of flow was adjusted to raise the systolic pressure to 120 to 160 mm. as quickly as possible. Upon restoration of sinus rhythm the infusion was slowed to 10 to 20 drops per minute and terminated shortly thereafter. This technic was successful only when the blood pressure became elevated to normal levels, which suggested that the elevation of the blood pressure stimulated receptors in the aorta and carotid sinus causing reflex stimulation of the vagus.

Atrial Flutter.—When auricular flutter persists after digitalization, quinidine may be used in the same manner as in the case of auricular fibrillation. In persistent flutter, the drugs which have been described may be used, frequently with success.

Atrial Fibrillation.—Without discussion of the role of digitalis in the treatment of persistent auricular fibrillation but in relation only to paroxysmal auricular fibrillation or to the attempt to revert the arrhythmia to sinus mechanism, the drug of choice is quinidine, which usually may be given by mouth.

Quinidine is so useful in the treatment and prophylaxis of nearly all arrhythmias that it seems wise to review its chief therapeutic actions, which are as follows:

Prolongs the refractory time of heart muscle
Slows the conduction time in heart muscle
Exerts an antifibrillary action
Depresses the excitability of heart muscle
Depresses the rhythmic function of the sinoauricular node and the ectopic pacemakers
Slows the electrical systole
Reduces the contractile force of the heart muscle
Produces ventricular tachycardia (after very large doses)
Blocks the vagus in the heart, thus when unapposed by other effects the heart rate is increased
Causes a fall in systolic blood pressure (after huge doses only, perhaps by blocking the epinephrine action on the blood vessels)

The toxic manifestations of quinidine include impairment of hearing, tinnitus, blurred vision vertigo, tremor, nausea, vomiting, abdominal cramps and diarrhea. In addition, the therapeutic action may become toxic; for example, depression of auriculoventricular conduction to maintain a normally slow ventricular rate is therapeutic, but it becomes toxic if the depression is sufficient to cause complete heart block. The toxic effects which, though usually preceded by the symptoms mentioned, must be looked for are undue prolongation of the auriculoventricular conduction, varying degrees of heart block, intraventricular block premature beats and ventricular tachycardia.

It is important to have a definite plan, a dosage schedule which should be adhered to in the attempt to abolish the abnormal rhythm with

out producing serious toxic effects. The particular scheme is not so important as it is to adhere to the schedule which has been selected and to become familiar with it. There is a personal preference for the natural quinidine rather than the synthetic drug.

Treatment may be started with a dose that is known to be safe and increased if needed. Although allergic sensitivity to quinidine is unusual, there should be questioning and observation after the first dose with such sensitivity in mind. The peak effect of the oral dose develops in two to four hours and is gone in about 12 hours; thus the dose should be repeated every three hours, for example, and the patient observed before each new dose to see if the objective has been reached and to watch for possible toxic effects. It is a personal preference not to be in a hurry to reach the higher doses since normal rhythm is so frequently established with smaller amounts. Thus 0.2 Gm. may be given the first day for six doses. If necessary to continue, the dose may be 0.4 Gm. every three hours on the second day, 0.6 Gm. every three hours the third day, and rarely 0.8 Gm. every three hours on the fourth day. In this way the intensity of the quinidine action gradually increases until the desired result is obtained or the attempt abandoned.

When regular rhythm has been restored, it is wise to give prophylactic doses, usually 0.2 Gm. or 0.4 Gm. four times daily depending upon the amount of quinidine which has been required, and to continue until such time as it seems wise to attempt to reduce and perhaps eventually omit the quinidine in the hope that the heart muscle has established the habit of remaining under control.

It is of some practical interest to consider what happens in the heart with atrial fibrillation during this type of quinidine therapy, as elucidated by Gold and others. Whether or not a circus movement is present, there are in the auricles, in this mechanism, impulses at a rate of about 400 to 500 per minute, mostly blocked at the auriculoventricular node so the ventricular rate is perhaps 120 or so. As the quinidine action takes place, the number of these impulses is reduced, but often the quinidine simultaneously blocks the vagus, thereby diminishing the auriculoventricular block with a resulting rise in the ventricular rate while the rate falls in the fibrillating auricles.

When the rate in the auricles falls to around 300 to 350 a minute, the mechanism usually changes from auricular fibrillation to auricular flutter, perhaps with a 2:1 ratio. As the quinidine effect persists, the auricular rate continues to slow with a fall in the ventricular rate. When the auricular rate falls to about 200 per minute, the 2:1 block disappears because the auriculoventricular node is rarely refractory to a rate of 200 and at this point the ventricles begin to respond to all of the auricular impulses; therefore, the ventricular rate suddenly rises. Quinidine should not be stopped at this time because while the auricular rate is slowed, the refractory time is also being prolonged, and when it becomes sufficiently long, there occurs an abrupt end to the abnormal mechanism. At that moment the heart temporarily is left without a pacemaker, but after a few seconds the sinoauricular node resumes its rhythmic discharge, usually at a normal rate. There are variants of this pattern such as a pronounced vagal depression which lifts the auriculoventricular block while the auricular rate is very rapid. Sometimes failure of restoration of normal rhythm is due to an unfavorable balance between the prolonged refractory time, which tends to abolish the abnormal mechanism, and to slowing of conduction, which tends to promote it. Whenever the ventricular rate appears to have been slowed, it is wise to have an electrocardiogram to see if sinus rhythm has been restored but kept rapid by action of the vagus.

There are varying opinions concerning quinidine and digitalis combined in the attempt to revert auricular fibrillation to normal sinus mechanism. Some have expressed opinions advising against the simultaneuos use of the two drugs as opposed to those who advise such usage. There are reports of success in the use of quinidine for this purpose following digitalization, and perhaps an equal number of reports of success by the use of quinidine alone.

Theoretic considerations must take into account that quinidine prolongs the refractory time in the heart muscle and tends to slow conduction, but usually the effect on the refractory phase is predominant. Digitalis tends to shorten the refractory time by vagal stimulation and by direct effect on the heart muscle while it tends to accelerate conduction in the auricle; consequently its effect in abolishing the abnormal mechanism would depend upon which of these actions is predominant. If one could combine the effect of quinidine in prolonging the refractory time with the effect of digitalis in speeding up conduction,

without the other and apposing effects of the two drugs, the result would be ideal, theoretically, in abolishing the abnormal mechanism. It appears that such an additive effect of the two drugs does occur in some patients.

There are other combinations of effects, however, which may promote the arrhythmia; for example, in the auriculoventricular node digitalis slows the speed of conduction by reflex vagal stimulation and by direct action on the node. Quinidine has two conflicting actions, one to slow conduction by direct depression of the node and the other to accelerate conduction by blocking the vagus function. Thus the two drugs may act to slow the heart rate by blocking the auriculoventricular conduction, or the heart rate may increase when quinidine blocks the vagus sufficiently to erase the vagal stimulation of the digitalis. The effect of the use of the drugs in my opinion is unpredictable. If quinidine used alone fails in its purpose, then digitalis may be added in the hope that the additive effect will be a beneficial one. When congestive failure is present, one is usually obliged to use digitalis as well as quinidine. If sinus mechanism is not restored in such a patient, it may be proper to omit the digitalis until much of its effect is dissipated and then to try quinidine alone.

Ventricular Tachycardia

Unlike the supraventricular arrhythmias, ventricular tachycardia rarely if ever occurs in a normal heart. It may be due to digitalis poisoning and is often present after myocardial infarction. It is important to abolish this tachycardia with as little delay as possible.

Procaine amide hydrochloride (Pronestyl) is the treatment of choice and may be given by mouth, 500 mg. every three hours, if more rapid action is not imperative, in which case the drug may be given by vein in a suitable diluent at a rate of 100 mg. per minute until an effect is obtained. During administration of Pronestyl by vein an electrocardiogram should be obtained in order to note a change in rhythm or evidence of toxic effect, either of which calls for cessation of the drug. The blood pressure should also be observed, and if a decided fall occurs, it may be countered by a vasopressor drug such as Neo-Synephrine or Levophed. Usually, Pronestyl will be effective with a dose less than 500 mg. by vein if at all. The oral dose required may be as much as 5 to 10 Gm.

Quinidine is of less value than in the treatment of the supraventricular tachycardias and is somewhat more hazardous because of its possible toxic and depressant effect upon injured and diseased ventricular tissues; but it may be given by mouth as described for auricular fibrillation or may be used intramuscularly in any of the preparations which are now on the market such as quinidine hydrochloride, or quinidine sulfate in propylene glycol. The intramuscular dose is approximately the same as required by mouth. When all else fails, quinidine may be given by vein if the situation demands it, 0.2 Gm. each few minutes with electrocardiographic control.

Isopropylnorepinephrine has been used in patients with complete heart block for the prophylaxis of ventricular tachycardia and for ventricular fibrillation in patients with recurrent Stokes-Adams syncope due to these arrhythmias. It was administered by continuous intravenous infusion to accelerate the idioventricular pacemaker, thus preventing, presumably by dominance, additional aberrant rhythms. This drug has been reported also to stimulate multifocal ventricular activity. When all else fails, it may be worthy of trial.[3,4]

Levarterenol (Levophed) has been reported as a useful agent similarly employed.[2]

Magnesium sulfate has been used successfully and may still be tried if other measures fail. This drug may be injected with moderate rapidity, 10 to 20 cc. in 20 per cent solution (2 to 4 Gm.).

Morphine sulfate has been found to abolish ventricular tachycardia on occasion given by vein in small doses, 10 mg. or more, not repeated in less than one hour.

Ventricular Fibrillation

When a patient with ventricular fibrillation survives sufficiently long for the diagnosis to be evident, the occasion is apt to be during anesthesia or other procedures during which electrocardiographic control is being observed. It may follow myocardial infarction or may be a result of drug toxicity. When due to electric shock, it is usually rapidly fatal, as in the electric chair. Whenever patients with ventricular fibrillation remain alive more than 20 to 30 seconds, there may be seizures resembling the Stokes-Adams episode. The nature of the underlying mechanism must be distinguished from the other causes of such seizures, namely temporary asystole and complete heart block. Drugs which are useful in the latter conditions, such as epinephrine and ephedrine, may be harmful in the case of ventricular fibrillation. There is no dependably useful therapy. Oxygen is imperative. Procaine or Pronestyl, or even quinidine may be given intravenously. There have

been reports of the successful use by vein of atropine, potassium chloride and magnesium sulfate. The maneuver of electric defibrillation with special apparatus should be anticipated and prepared for in the operating room, but is apt to be less effective when the arrhythmia occurs as a result of disease than when it is an accident secondary to anesthesia and surgery.

Isopropylnorepinephrine may be used in the same manner as mentioned in the case of ventricular tachycardia.

Complete Heart Block

The treatment for complete heart block is aimed at relief and prophylaxis of the Stokes-Adams syndrome. Mechanical stimulation by sharp blows over the precordial area may increase the heart rate sufficiently to end the episode. Stimulation by the electric cardiac pacemaker may be useful. Epinephrine in small dosage by vein, or in extreme emergency directly into the heart muscle or a heart chamber, may be attempted. This drug may be repeated, in the case of recurring seizures, by the subcutaneous route, or may be given intramuscularly in oil. Ephedrine, 25 mg., Paredrine, 30 mg. by mouth, and Isuprel, 15 mg. sublingually, have been of value. Isopropylnorepinephrine may be used as described.

Sodium Lactate has recently been reported as useful after cardiac arrest and in Stokes-Adams seizures in patients with complete heart block. Although the mechanism of its effects is not clearly defined, the intravenous molar and half molar solutions have been used to restore the heart beat after attempts by other drugs proved useless. An intravenous infusion has been maintained, with good results, for several hours.[5]

Summary

The treatment of cardiac arrhythmias by drugs has been discussed with particular reference to quinidine therapy. Mention is made of the usefulness of numerous drugs including some of the more recently introduced preparations and methods of use.

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ABSTRACTS

Analysis of the Foot in Infants. THE RADIOGRAPHIC CRITERIA AND CLINICAL ASPECTS. By William S. Hatt, M.D., and Lawrence A. Davis, M.D. South M. J. 50:720-724 (June) 1957.

The authors describe their scientific evaluation of the normal and abnormal infant foot in the attempt to correct deformities properly. Their analysis is based on a standardized radiographic technic. The so-called normal infant foot or its neutral position, clubfoot, rocker deformity, flatfoot and metatarsus varus, metatarsus valgus and pes cavus are analyzed from the standpoint of TC or talocalcaneal angle both in lateral and anteroposterior projections. The inferior cortical line of the fifth metatarsal and calcaneus, midshaft lines of the first and fourth metatarsals and the midshaft lines of all the metatarsals are utilized in analysis of the forefoot. Since the conditions discussed may be considered as positional changes of otherwise normally developed bones and joints of the infant foot, it is believed that comprehensive analysis of these positional changes will prove essential for their accurate diagnosis and treatment as well as in future investigation.

A brief discussion of the milder deformities is presented, and the problems of clubfoot and flatfoot are also discussed. This analysis should be useful in dealing with the difficult problem of what deformities to treat and how far they should be corrected.

Use of Meprobamate (Miltown®) for the Treatment of Emotional Disorders. By Roger E. Phillips, M.D. Am. Pract. & Digest Treat. 7:1573-1576 (Oct.) 1956.

This study indicates that of the ataractic drugs, meprobamate is probably of the greatest aid in tension states and the like, in terms of its effectiveness and low rate of side reactions. Of 135 psychiatric patients treated with Miltown in private practice, improvement of anxiety, tension, insomnia and psychophysiologic symptoms occurred in approximately three fourths. Endogenous depressions responded poorly, but when depressions were secondary to anxiety reactions, whether acute or chronic, these improved as readily as the anxiety. The author found Miltown to be the safest and most effective drug available for the treatment of emotional disturbances in private practice.

Injuries of the Spleen. By John H. Terry, M.D., Milton M. Self, M.D., and John M. Howard, M.D. Surgery 40:615-639 (Sept.) 1956.

In this comprehensive article with extensive bibliography the authors discuss their subject from the standpoints of history, anatomic and physiologic considerations, incidence, types of injury, associated injuries, anatomic types of injury, spontaneous rupture of the normal spleen, rupture of the diseased spleen, delayed rupture, diagnosis, management with resulting morbidity and mortality, effects of splenectomy and splenosis. They then analyze the results of therapy of 102 consecutive patients with splenic injury, observed in a teaching center over a period of 10 years.

Of the 102 patients with ruptured spleens treated from 1946 to 1955, 49 had received penetrating injuries and 53 blunt injuries. Associated injuries to other organs were present in 72 per cent of the total series. Thoracic injuries, fractures, and intracranial injuries were often associated with the splenic injury caused by blunt trauma. With penetrating wounds, injury to the intestinal tract was the most frequent complicating injury. Following the two types of injury, the mortality of patients reaching the hospital alive was the same, 24 per cent. Approximately one third of the patients died preoperatively, chiefly of intracranial injuries secondary to blunt trauma. Of the total deaths in the entire period (25 patients), 48 per cent were due directly to hemorrhage, 28 per cent to intracranial injury, and 12 per cent to post-traumatic renal insufficiency. Mortality rates were directly proportional to the magnitude of injury as represented by the total number of organs injured. When the spleen alone was injured, the mortality rate was only 10 per cent.

Of the patients with penetrating injuries, bullet wounds were the most common mode of injury and resulted in the highest mortality rate (44 per cent). There were no deaths among the 21 patients with stab wounds. Of the 53 patients with blunt injuries, auto accidents comprised the largest group (34 patients) and resulted in a 26 per cent mortality. Falls resulted in the injury of eight patients, three of whom died (37 per cent).

Of the 91 patients who had immediate rupture, 25 died, a mortality rate of 27 per cent. Of 11 patients with delayed rupture, none died. Following splenectomy for immediate rupture, the mortality from penetrating injuries (25 per cent)

was higher than that from blunt trauma (12 per cent), although there was a significantly shorter time lag prior to surgery in the former group. The high incidence of associated injuries accounted for the higher mortality.

Three fourths of the patients with delayed hemorrhage bled secondarily within two weeks of the initial injury, a fact which suggests that patients suspected of having a splenic contusion should be warned of this possible complication.

The authors observed that improvements in therapy during this 10 year period resulted from improved blood bank facilities and improvements in emergency care by the resident surgeons. Additional improvement, they concluded, depends primarily upon the improvement of technics in controlling intra-abdominal hemorrhage.

Spontaneous Rupture of a Uterine Varix at 28 Weeks' Pregnancy. By T. Vernon Finch, M.D. Am. J. Obst. & Gynec. 72:1189-1190 (Dec.) 1956.

Spontaneous rupture of the veins of the uteroovarian system during pregnancy is an overlooked cause of sudden maternal collapse and sudden death. Because of its infrequency, and because no trauma is involved, the diagnosis is seldom made, and consequent indecision as to management can be tragic. Most obstetric textbooks omit mention of this clinical entity. A case of spontaneous rupture of a uterine varix at 28 weeks' pregnancy is reported, and the salient features of such anomalies are pointed out.

Congenital True Esophageal Diverticulum. Report of a Case Unassociated with Other Esophagotracheal Abnormality. By Arthur R. Nelson, M.D. Ann. Surg. 145:258-264 (Feb.) 1957.

Esophageal abnormalities take many forms, but it would appear that a true diverticulum of the esophagus, that is, an outpouching containing all normally present anatomic layers of esophagus and occurring as a congenital defect, is indeed a rare anomaly in the human. In the case reported here the esophageal diverticulum represents a congenital true diverticulum, unassociated with the cricopharyngeal mechanism and unassociated with esophageal stenosis, tracheal communication, or other apparent esophageal abnormality. In this unusual case surgical treatment by partial excision and endoscopic forceful dilatation produced a satisfactory functional result.

Contact Dermatitis Due to Hydrocortisone Ointment. Report of a case of Sensitivity to Emulsifying Agents in a Hydrophilic Ointment Base. By Wiley M. Sams, M.D., and J. Graham Smith Jr., M.D. J. A. M. A. 164:1212-1213 (July 13) 1957.

A case is reported which illustrates the importance of medicaments used for topical therapy being as nonsenitizing as possible. In this instance, a contact dermatitis developed despite the presence of 1 per cent hydrocortisone in the hydrophilic ointment base. The sensitivity was the result of allergy to free and sulfated higher alcohols. These substances, especially sodium lauryl sulfate, are widely used in ointment bases, cosmetics, detergents, and other preparations which come into contact with the skin. Because of the common occurrence of contact dermatitis, and since many preparations contain the substances listed and other offenders, information concerning the ingredients of preparations for topical use should, in the opinion of the authors, be more readily available.

Reflux Ureteropyelograms in Children. By John I. Williams, M.D., Russell B. Carson, M.D., and W. Dotson Wells, M.D. South. M. J. 50:845-851 (July) 1957.

The purpose of this paper is to stress the ease with which cystography may be used in making a study of the young patient suspected of having a urologic problem. It is not only an available diagnostic adjunct, but in the opinion of the authors should be considered an indispensable diagnostic aid in the complete evaluation of a pediatric urologic problem. By means of this tool, one is able to demonstrate vesicoureteral reflux when other diagnostic procedures have offered little information. The technic is described, and three cases are presented to illustrate the invaluable aid which can be given by the simple and often unused procedure of cystography in the treatment of vesicoureteral reflux in children. Physicians who carry out urologic studies in children are urged to incorporate cystography as one of their routine diagnostic procedures.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

President's Page

Progress Yet Antiquation

"What was good for our forefathers is good enough for us." This in days gone by was an influential quotation and was strongly adhered to in opinions as well as actions. Today, however, this philosophy draws but little water. We physicians know that Progress is the forerunner of Antiquation. Progress does not come about spontaneously. It demands effort. We have made great progress in recent years scientifically and socioeconomically in our profession; yet, some seem to think that we can continue to do so without effort and with more or less antiquated methods. There are those who think and act as though our professional and socioeconomic welfare will continue into the seemingly bright future with great success whether any effort is exhibited or not on their part. They should not count their chickens before they are hatched.

Surely we are making progress in scientific, sociomedical and economic medicine and enjoying the product of our labors. Can we continue to so do? I think we can.

When Gen. Robert E. Lee surrendered at Appomattox, mounted Old Traveler, and turned his head south, it was not in defeat. It was because we could not win long enough. Yes, we are apparently winning, but can we continue to win long enough? I hope we can.

Is our present position in the economics of medicine as well as in public relations just a holding action? I think it is. I am of the opinion that we should turn on the steam, and do it now, in order to convert our holding action into a potent offense.

Right now we have a formidable weapon at our disposal. This mighty weapon is BLUE SHIELD of FLORIDA. This instrument, when it was first organized and put into action, represented real progress. It has done more to thwart socialized medicine than any other single measure. It has greatly aided the doctors to help people who were unable to help themselves. It has helped to lift the charity load from the doctor's shoulders. It has greatly benefited the medically privileged. It has been a haven of refuge for the medically underprivileged. Wonderful has it been and still is; yet, it is antiquated as it exists today in serving its purpose in the economy of the individual, both patient and doctor. This antiquated instrument is only being used now for holding action purposes and as such is fast slipping. It is time for this weapon to be overhauled and reconditioned, or replaced by a more modern one. Perhaps it would be better both to overhaul and replace.

Your state Association through its Advisory Committee to Blue Shield is making a heroic effort to do just that. The Committee of Seventeen, as it is unofficially known, is working hard to get the opinions of all the members of our Association in order that it may come up with the best recommendations for the directors of Blue Shield to try to comply with in their efforts to modernize this weapon. Your individual and collective opinions are essential if this objective is to be accomplished. If you want a voice in the affairs of your Association and its satellites, now is the time to speak up. Your officers and committees cannot hear silence. Think before you speak, but do both. Keep in mind that Antiquation follows in the footprints of Progress.

Wm C. Roberts

THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. Box 2411 Jacksonville, Florida

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Asiatic Influenza Epidemic — Fact or Fancy

At a recent meeting on Asian influenza Surgeon General Burney of the U. S. Public Health Service stated, "If we do have these epidemics and we have not done everything possible in preparation, we will be subject to more criticism and we will have to face our conscience." He added that he hoped the public would understand the situation without hysteria. Rather than the public becoming hysterical, it is more than likely that the comic side of the situation will make its deepest impression on the American people. A few nights ago, on his program, Jack Paar opened a Chinese fortune cookie and read, "Hello American, you now have Asiatic flu!"

Cases of Asian influenza have so far been marked by temperatures of 102 to 104 F., headache, sore throat and muscle aches. The fever lasts three to five days followed by weakness for several more days. The attack rate in the Far East was approximately 20 per cent with a death rate of two-tenths of 1 per cent. Surgeon General Burney went on to say: "Other respiratory infections will occur which are virtually indistinguishable from influenza except by laboratory tests. Laboratory tests in this event only tend to pinpoint the possibility of an epidemic being present in a certain area."

The Surgeon General has also announced that the first supplies of the vaccine against Asian influenza are expected to become available to the public during September. It is possible that 60 million cubic centimeters (doses) will be produced by February first. Manufacturers have been asked to produce the vaccine as rapidly as possible. Of the projected eight million doses available by mid-September 1957, four million doses will be used by the military, leaving four million doses for a country of 170 million people. It is further a fact that there will not be enough time to produce and administer sufficient vaccine to immunize the majority of the population before the influenza season begins.

The virus of Asian influenza is apparently a new strain and people have built no natural immunity to it, nor is it known that one attack confers an immunity. "There have been a few local outbreaks in the United States this summer, but because of its swift onset and short duration,

reports on incidence are difficult to obtain," Dr. Burney said. Assuming an attack rate of 10 to 20 per cent in this country, this would mean that a city of one million persons could have 100 to 200 thousand cases, not necessarily at the same time. Past experience, according to the Public Health Service, has indicated that a single injection of the vaccine will be about 70 per cent effective. Protection develops in 10 to 14 days and is supposed to last one year. As to whether this is a statement of fact or prophecy remains to be proved. The cost of the vaccine to the individual has not been determined, but in large military orders the cost was 20 to 40 cents per cubic centimeters.

As supplies become available to the public, the Public Health Service will recommend that particular consideration be given to the immunization of those whose services are imperative for the care of the sick and those needed to maintain other essential functions. It is further proposed by the Public Health Service that the priorities be issued on the basis of the various categories of personnel involved. The American Medical Association has assured the Surgeon General that community resources, both public and private, will be able to provide inoculations for persons who are unable to pay for such protection.

Antibiotics are of no value in fighting influenza itself, but may be helpful should unlikely complications develop. Public Health Service laboratories are investigating acute respiratory diseases and, in addition, are testing and evaluating the vaccine. It is planned to keep the public and the medical and health professions informed on nationwide developments in the influenza picture and on the supply, distribution and use of the vaccine.

It is possible that the advance publicity may outstrip its own usefulness. Resentment may develop as people are educated to the value of the vaccine and then cannot get it, either because the vaccine is not available, or they are not on a high enough priority list. It is further admitted, as stated by Dr. Cutler of the Public Health Service, that the effectiveness of the vaccine will not be known beyond doubt until it has been tested in the midst of an epidemic.

To sum up the situation regarding Asian influenza at this time, it is the feeling of the Public Health Service that: (1) The disease is well seeded all over the country and that we are just waiting for the epidemics to come. (2) The best proposal is to handle as many of the problems as possible on the local level with professional and other groups cooperating. It was stated that the Public Health Laboratories and State Laboratories should not be overburdened and that local laboratories should be used as much as possible. The only possible use that can be made of the laboratories is to establish, if possible, that Asiatic influenza is present, but more than likely by the time the report can be received the patient will be safely convalescing. Care of the sick should be conducted in the homes, admitting to hospitals only those patients with complications. (3) Immunization should be performed in an orderly manner, immunizing the largest number possible, taking into account the priorities. This naturally involves the problem of production and shortage of the vaccine. (4) Information is being disseminated, and more will be, on two levels: (a) the epidemiologic level where information is being passed out to medical and allied professions, and (b) the public level, where the public will be informed of the true facts. If the same obtains as that which occurred during the discussion of radioactive fall out, the public will receive very few of the facts. Let us hope that this will not be the case.

The wisdom of so much advance warning may negate an otherwise successful campaign to encourage people to receive inoculations. It is the hope to prevent this disease, which in all aspects is hardly much worse than a common cold, and its morbidity rate is no greater than that which has been experienced by similar outbreaks all over the country during the winter months of the year. It must be kept in mind that this is not a disabling disease as is true with poliomyelitis. Even with poliomyelitis the public actually had to be rocked out of its complacency and forced by the American Medical Association, through the state and county medical societies by means of an extensive campaign, to have the children and younger citizens inoculated.

There is one great danger in all of this publicity. The public will not stand for the cry "wolf" if something does not materialize, for, if epidemics do not develop after all this publicity, there may come a time when a serious epidemic will arise and the public will pay no attention to the warning! In addition, there should be no jockeying for prestige among government or private services as to who shall receive the credit (or the blame) for warning the public and controll-

ing the situation, or else receiving the blame for something which they prophesied and which did not come true. Already children entering colleges in certain parts of the country are receiving instructions for inoculation before they return to school when it is a known fact today that vaccine will not be available, and perhaps not until the last of next year in any considerable quantity. By that time the epidemic season will have passed, and if there is no more damage than has been done in the Far East, there is very little for this country to worry about.

Association Program to Combat Possible Asian Influenza Outbreak in Florida

As of September 1, Florida was one of at least 14 states which had reported cases of confirmed Asian influenza. In mid-August all members of the Florida Medical Association received a memorandum from Dr. Richard G. Skinner Jr., chairman of the Committee on Asiatic Influenza, alerting them to the known presence of the disease in the state, pointing out its characteristics and presenting the current information regarding the prospects for vaccine.

Recently, Dr. Skinner again directed the attention of Association officials to the major considerations regarding possible significant outbreaks in the state. The disease appears to be mild, but there is always the possibility that it could change and become lethal. Present plans are to administer the vaccine first to physicians and hospital personnel and then to people in essential services. A strong drive should be made when the vaccine first becomes available to get the doctors to immunize themselves and their staffs and to get the hospitals to immunize their personnel. As more vaccine becomes available, preference should be given to persons with chronic debilitating disease.

How active should the Association be in pushing immunization of the general public? It appears now, in early September, that unless the picture changes materially, it will be sufficient for the individual physicians to tell their patients, and for the Association and other sources of information to let it be known generally, that the vaccine has become available to the general public. Those who desire it will then turn to their private physicians to get the measure of protection the vaccine offers.

In general, the attack rate varies, but seems to be from 10 to 16 per cent, or more, of the population in affected areas elsewhere in the world. A severe epidemic could well pose a serious economic problem in this state, even though the disease is of relatively short duration. It is characterized by rapid onset, fever, malaise, aching muscles and coryza, with the symptoms lasting from three to five days. The infective agent is the virus Japan 507 of 1957, and the incubation period is probably from one to two days. The contagious period, while uncertain, is estimated at from one to five days. The mortality rates have been low.

The public should be made conscious of the importance of home care, especially in the event of a major outbreak, however mild. The problem of hospitalization is acute enough as it is without any unnecessary excessive overcrowding that could easily occur in the presence of an epidemic of Asian influenza.

Dr. Skinner and his committee members are keeping abreast of the situation, as are the Association officers. They urge the membership to watch for and heed such information as is disseminated from time to time by the Association through the component county societies and that which comes from other official sources.

Small Business Administration New Loan Policy

Under a recent policy change, the Small Business Administration can now make loans to physicians, surgeons, and others engaged in professional services, according to James F. Hollingsworth, Regional Director of SBA, in Atlanta. Previously SBA had not been permitted to make loans to professionals, since these were not considered strictly as qualifying within the meaning of the Small Business Act.

With the new policy, the agency can make loans for the following purposes: (1) To finance constructions, conversion, or expansion of hospitals, clinics, or offices to be used for professional services; (2) to finance the purchase of equipment, facilities, supplies, or materials; and (3) to meet other operational needs.

SBA does not make loans where capital is available on reasonable terms from banks or other private lending agencies. Applicants, therefore, are advised to have letters from two banks to the effect that the banks cannot supply the

capital as needed. If the local bank cannot make the total loan, it is asked to participate in the loan with SBA. If the bank cannot participate, SBA may then make a loan direct.

To qualify for consideration for either a participation or a direct loan, the applicant must be considered as operating a small business and must meet certain practical credit requirements. Since any firm employing fewer than 250 persons is considered small, applicants from the medical professional would not ordinarily be affected by the size provision.

To be eligible for a loan, an applicant must be of good character, have the ability to operate his business successfully, and have enough capital so that, with loan assistance from SBA, it will be possible for him to operate on a sound financial basis. His past earnings record and future prospects must indicate ability to repay the loan out of income.

The maximum amount of a direct SBA loan, or of SBA's part in a participation loan, is $250,000, with a maturity limit of 10 years. The interest rate cannot be more than 6 per cent, and may be less in the case of a participation loan, if the participating bank charges a lower rate.

It is suggested that any member of the medical profession who previously inquired about an SBA loan and was not encouraged to file an application, on the basis that he did not qualify as having a "small business," should contact SBA and ask that his application be reconsidered. The regional office of SBA is located at 90 Fairlie Street, N. W., Atlanta 3, Ga., and there is a branch office for the State of Florida located at 327 Northeast First Ave., Room 310, Miami 32. SBA personnel at either of these offices will be happy to give advice and assistance in the preparation of an application. No appointment is necessary. Copies of applications and a copy of a pamphlet, "SBA Business Loans," may be had from the regional office on written request.

Environment of Good Cheer and Hope For the Mentally Ill

Entitled "New Hope," a picture story about a good public mental hospital, which was recently published by the National Association for Mental Health, will be of interest to the physicians of Florida. Its 27 photographs trace the progress of a mentally ill person from illness back to health. It shows clearly and positively the kind of care and treatment the patients, their family and the community should expect and demand from public mental hospitals. A free copy awaits any physician who will request it from his local mental health association or from the Florida Association for Mental Health, 1016 La-Salle St., Jacksonville 7.

This illustrated booklet can be used to help a mentally ill person or his family obtain early hospital treatment, to eradicate common misconceptions about the mental patient and the public mental hospital, and to win support for better public mental hospitals through mental health associations. The photographs were taken in Crownsville State Hospital, Maryland, and sev-

Scientific Papers, Exhibits and Films Requested for Association's Annual Meeting

The Scientific Work Committee of the Florida Medical Association has requested that members of the Association desiring to apply for places on the scientific program of the Eighty-Fourth Annual Meeting contact Dr. George T. Harrell Jr., Chairman of the Committee, College of Medicine, University of Florida, Gainesville.

The scientific program will be divided into three phases—papers, exhibits and films.

Members desiring to present papers on the program of the Scientific Assemblies should submit an abstract of about 50 words on the subject they plan to discuss. For places on the scientific exhibit program, a photograph or sketch of the exhibit together with a brief description of the subject should be submitted. As for films, a short description of the content is necessary. Films should not be more than 20 minutes in length.

Dr. Harrell has announced that the deadline for submitting applications is November 1. He and his Committee will meet in Gainesville on November 16 to select the papers to be presented and the exhibits and films to be shown.

Serving with Dr. Harrell on the Scientific Work Committee are Drs. Franz H. Stewart and Donald F. Marion, Miami; Dr. Richard Reeser Jr., St. Petersburg, and Dr. Gretchen V. Squires, Pensacola.

eral show Dr. Arnold H. Eichert, formerly head of that hospital and now Superintendent of the South Florida State Hospital in Hollywood.

This new Florida facility is situated on a 300 acre site 18 miles from downtown Miami, conveniently located to serve Southeastern Florida. It is one of the first mental hospitals to couple new medical and architectural concepts for a "cure-not-care" program. It is now believed that intensive treatment in proper surroundings with adequate facilities can cure the majority of mental patients rather than consign them to a lifetime of constant care.

The first of three phases of the building program at the South Florida State Hospital has been completed, and the first patients were recently received. The over-all plant will eventually provide 1,600 beds and 52 buildings, and will cost 15 million dollars. The second stage, now under construction, will provide a multipurpose recreation building and adjacent playing fields.

The hospital's master plan focuses attention on the individual as much as possible. Buildings are planned in small, one story units to keep patient groups small and to provide separation for quiet, depressed, or disturbed types. Each building has its own patio or recreation yard. Although most patios are enclosed, an attractive lattice effect



A typical recreation field at the South Florida State Hospital, with gymnasium in background. Physical recreation as an aid in restoring mental health is encouraged. Patients live and are treated in the adjoining one story buildings which are connected by covered walkways.

is achieved from the artful use of concrete block, giving the appearance of a decorative garden wall rather than a confining steel fence.

As the accompanying photographs illustrate, throughout the grounds and in the design of the buildings the architects have tried to provide restful and hopeful surroundings. This architectural concept is a definite part of the mental health program in keeping with the new theories and practices in the treatment of the mentally ill. The objective of this new approach is to return discouraged, disturbed and frightened pa-



Entrance to one of several treatment and receiving buildings at the South Florida State Hospital at Hollywood. Interior plan of treatment and receiving sections includes physicians' and psychiatrists' offices and therapy rooms.

tients to healthy and useful lives. Florida may well be proud of its new mental hospital, beautifully designed to demonstrate the value of physical environment as a therapeutic aid in helping to cure the confused mind struggling to find reality. In this noteworthy architectural achievement the architects are already beginning to realize their hope "that here will be some elements of 'that environment of good cheer and hope' . . . that place where a patient may 'find a situation in which he is acceptable' . . . that garden where a man may find himself again."

Medical District Meetings—October 28-31

Two scientific papers on the management of gastrointestinal bleeding, one on the medical aspect and the other on the surgical, will be featured on the program of the scientific assemblies of the Eighteenth Annual Medical District Meetings beginning October 28 in Panama City.

The programs for the meetings have been released by Dr. S. Carnes Harvard, of Brooksville, Chairman of the Council of the Florida Medical Association. In arranging the programs, Dr. Harvard was assisted by the councilors of the particular medical district.

The scientific subjects are the same for each meeting, however, the speakers have been selected from the area in which the meeting is being held.

Following the precedent of previous meetings, a general session will be held after the scientific assemblies. The programs and speakers for these sessions are identical for each medical district. Appearing will be Dr. Homer F. Marsh, Dean of the School of Medicine, University of Miami; Dr. George T. Harrell Jr., Dean of the College of Medicine, University of Florida; Mr. Thomas A. Hendricks, Field Director, American Medical Association, Chicago; Drs. Edward Jelks, Jacksonville; John D. Milton, Miami; Henry J. Babers Jr., Gainesville; Francis T. Holland, Tallahassee, and the officers of the Florida Medical Association: Dr. William C. Roberts, President; Dr. Jere W. Annis, President-Elect; Dr. Samuel M. Day, Secretary-Treasurer, and Dr. Shaler Richardson, Editor of The Journal.

Dr. Jelks will explain the purposes and function of the Florida Medical Foundation; Dr. Milton will discuss Medicare; Dr. Babers Blue Shield, and Dr. Holland will discuss two subjects: the World Medical Association and Rural Health.

Following the meeting in District A at Panama City October 28 will be the meeting in District C at Clearwater on October 29; District B at Orlando on October 30 and District D at Fort Pierce on October 31.



Dr. S. Carnes Harvard, of Brooksville, Chairman of the Council of the Florida Medical Association, who with the assistance of the district councilors arranged the programs for the Eighteenth Annual Medical District Meetings being held October 28-31. Dr. Harvard will serve as a presiding officer at the meeting in each medical district, assisted by the councilor of the district.

Each meeting is scheduled to begin at 2:00 p.m. At 6:00 refreshments are to be served followed by dinner at 7:00.

Activities of the Woman's Auxiliary at the Medical District Meetings have been announced by Mrs. Perry D. Melvin, of Miami, President. The program in each district will begin at 2:00 p.m. At Panama City, the meeting is being held in the Woman's Club at the corner of Cove Boulevard and 4th Street; at Clearwater in the Fort Harrison Hotel with registration beginning at 9:00 a.m.; at Orlando in the Orange Court Hotel and at Fort Pierce in the Pelican Yacht Club. A business meeting and tea is scheduled at Fort Pierce.

Scientific Assemblies

Panama City — A

Monday, October 28 - 2:00 p.m. (C.S.T.)
Dixie Sherman Hotel
Presiding: S. Carnes Harvard, Chairman of Council, and Alpheus T. Kennedy, of Pensacola, Councilor of District 1.
Address of Welcome, John J. Benton, President, Bay County Medical Society.
"Diagnosis and Medical Management of Gastrointestinal Bleeding," Charles J. Kahn, Pensacola.
"Diagnosis and Surgical Management of Gastrointestinal Bleeding," Frank E. Tugwell, Pensacola.
Discussion

Orlando — B

Wednesday, October 30 - 2:00 p.m.
Orange Court Hotel
Presiding: S. Carnes Harvard, Chairman of Council, and Leo M. Wachtel, of Jacksonville, Councilor of District 3.
Address of Welcome, Frank J. Pyle, President, Orange County Medical Society.
"Diagnosis and Medical Management of Gastrointestinal Bleeding," Frank C. Bone, Orlando.
"Diagnosis and Surgical Management of Gastrointestinal Bleeding," James M. Davis, Jacksonville.
Discussion

Clearwater — C

Tuesday, October 29 - 2:00 p.m.
Fort Harrison Hotel
Presiding: S. Carnes Harvard, Chairman of Council, and Gordon H. McSwain, of Arcadia, Councilor of District 6.
Address of Welcome, Percy H. Guinand, President, Pinellas County Medical Society.
"Diagnosis and Medical Management of Gastrointestinal Bleeding," George D. Hopkins II, Fort Myers.
"Diagnosis and Surgical Management of Gastrointestinal Bleeding," Richard A. Martorell, Tampa.
Discussion

Fort Pierce — D

Thursday, October 31 - 2:00 p.m.
Flamingo Restaurant, Shamrock Village
Presiding: S. Carnes Harvard, Chairman of Council, and Ralph M. Overstreet Jr., of West Palm Beach, Councilor of District 7.
Address of Welcome, John M. Gunsolus, President, St. Lucie-Okeechobee-Martin County Medical Society.
"Diagnosis and Medical Management of Gastrointestinal Bleeding," Fred E. Manulis, Palm Beach.
"Diagnosis and Surgical Management of Gastrointestinal Bleeding," Richard M. Fleming, Miami.
Discussion

Graduate Medical Education
Florida Clinical Diabetes Association, Gainesville, October 24-26, 1957

At the Medical Sciences Building of the College of Medicine of the University of Florida in Gainesville, the Florida Clinical Diabetes Association will hold its fifth annual meeting on October 24-26. Registration will begin at 8:30 a.m. on Thursday, October 24, and the fee of $10 carries with it the privilege of membership in the association. Dr. Edward R. Smith, President, of Jacksonville, announces that the annual luncheon and business meeting will be held on Friday, October 25, from 12 to 2 p.m. The final session will be concluded at noon on Saturday, October 26. Many registrants may wish to attend the football game between Louisiana State University and the University of Florida, scheduled for Saturday afternoon at 2:30.

The scientific program will be presented in cooperation with the Florida Medical Association, the Florida State Board of Health, and the Division of Postgraduate Education of the College of Medicine of the University of Florida. The opening lecture is scheduled for 9:30 a.m. on Thursday, October 24, and the closing feature on Saturday morning, October 26, will be a round table discussion.

Distinguished guests who will lecture are Dr. William R. Jordan, Associate Professor of Clinical Medicine, Medical College of Virginia, Rich-

mond, Va.; Dr. Roger H. Unger, Instructor in Clinical Medicine, Southwestern Medical School of the University of Texas, Dallas, Texas; and Dr. Cornelius J. O'Donovan, Director of the Orinase Research Project, Department of Clinical Investigation, The Upjohn Company, Kalamazoo, Mich. Florida physicians who will participate in the program include Dr. William C. Thomas Jr., Director of the Division of Postgraduate Education of the College of Medicine of the University of Florida, Gainesville; Dr. Sidney Davidson, Lake Worth; and Dr. Sanford A. Mullen, Jacksonville. Dr. Smith, Dr. Glen O. Summerlin, Gainesville, Dr. George H. Garmany, Tallahassee, the incoming president, and Dr. Joseph J. Lowenthal, Jacksonville, the association's secretary-treasurer will serve as moderators.

The program is as follows:

FIFTH ANNUAL MEETING
FLORIDA CLINICAL DIABETES ASSOCIATION
MEDICAL SCIENCES BUILDING, GAINESVILLE, OCTOBER 24-26

THURSDAY, OCTOBER 24

Moderator: Dr. Edward R. Smith, President

8:30	Registration	
9:30	"Diagnosis of Diabetes"	Dr. Jordan
10:10	"The Management of Diabetes with Oral Drugs"	Dr. Unger
10:50	Recess	
11:20	"Methods of Determining Blood and Urine Sugar and Their Clinical Interpretation"	Dr. Mullen
11:50	"The Prognosis in Diabetes"	Dr. Jordan

Moderator: Dr. Glen O. Summerlin, President
Alachua County Medical Society

2:00	"A Re-Evaluation of Insulin—Its Action and Mobilization"	Dr. Unger
2:40	Recess	
2:50	"The Unknown Diabetic in Your Practice"	Dr. Davidson
3:30	Recess	
3:40	"Renal Threshold and Bladder Residual as They Affect the Treatment of Diabetes"	Dr. Jordan

FRIDAY, OCTOBER 25

Moderator: Dr. George H. Garmany, Incoming President

9:30	"A New Diagnostic Test for Mild Diabetes"	Dr. Unger
10:10	"The Development of Orinase"	Dr. O'Donovan
10:50	Recess	
11:20	"Diabetes in Children"	Dr. Jordan
12:00	Luncheon Meeting of the Association	
2:00	(To be announced)	Dr. Unger
2:30	"Hypoglycemia"	Dr. Thomas
3:00	Recess	
3:10	"The Diabetic Foot"	Dr. Jordan
3:40	"The Mode of Action of Orinase"	Dr. O'Donovan

SATURDAY, OCTOBER 26

Moderator: Dr. Joseph J. Lowenthal, Secretary-Treasurer

9:30	"The Selection of Patients for Orinase Therapy"	Dr. O'Donovan
10:10	Recess	
10:20	Round table discussion—Dr. Jordan, Dr. Unger, Dr. O'Donovan, Dr. Thomas, Dr. Davidson, Dr. Mullen	

Florida Academy of General Practice Will Meet in St. Petersburg October 31 - November 2

The Eighth Annual Scientific Assembly of the Florida Academy of General Practice will be held at the Soreno Hotel in St. Petersburg. The proceedings will commence with registration at 5 p.m. on Thursday, October 31, followed by a meeting of the Board of Directors at 7 p.m., and will continue through November 1 and 2. The concluding event will be a banquet at 8 p.m. on Saturday, at which the principal speaker will be Dr. Malcom E. Phelps, President of The American Academy of General Practice.

Highlighting the program are Category 1 symposiums on antibiotics, anesthesia and biochemistry, arthritis, and stress conducted by top men in their respective fields. A delightful schedule has been arranged for the wives and children of members.

PROGRAM
EIGHTH ANNUAL SCIENTIFIC ASSEMBLY
FLORIDA ACADEMY OF GENERAL PRACTICE
OCTOBER 31 — NOVEMBER 2, 1957
SORENO HOTEL, ST. PETERSBURG

THURSDAY, OCTOBER 31

5:00 p.m. Registration
7:00 p.m. Meeting of the Board of Directors

FRIDAY, NOVEMBER 1

7:30 a.m. Registration
8:40 a.m. Invocation. Address of Welcome, Dr. Harry R. Cushman
Recognition of Dr. Malcom E. Phelps, President, American Academy of General Practice, and Dr. Henry L. Harrell, President, Florida Academy of General Practice

Symposium on Antibiotics

9:00 a.m. "Newer Antibiotics and Trends in Therapy," Dr. Ellard M. Yow
"Antibiotics in Pediatrics," Dr. James Hughes
"Untoward Reactions to Antibiotics," Dr. George T. Harrell Jr.
10:30 a.m. Review of Exhibits—Exhibit Hall
11:15 a.m. Symposium on Antibiotics continued:
"Steroids and Infectious Diseases," Dr. Ellard M. Yow
11:45 a.m. Questions to the Panel
12:00 Luncheon
1:20 p.m. Dr. William C. Thomas Jr., Director of the Division of Postgraduate Education of the College of Medicine of the University of Florida

Symposium on Anesthesia and Biochemistry

1:30 p.m. "A Simplified System Employing Surface Area Useful for the Management of the Majority Group of Fluid Imbalances," Dr. R. V. Kron
"Obstetrical Anesthesia," Dr. Robert A. Hingson
"Hypothermia in General Practice, Dr. Malcom E. Phelps
3:00 p.m. Review of Exhibits—Exhibits Hall
3:30 p.m. Symposium on Anesthesia and Biochemistry continued:
"Systemic Approach to the Diagnosis of Clinical Fluid Imbalances," Dr. R. V. Kron
"Oxygen in the Physician's Satchel," Dr. Robert A. Hingson
4:30 p.m. Questions to the Panel
Dinner
8:00 p.m. "Malpractice Litigation: Causes and Cures," Franklin J. Evans, M.D., LL.B.
Business Session—Dr. Henry L. Harrell, President, in the Chair

SATURDAY, NOVEMBER 2

Symposium on Arthritis

9:00 a.m. "The Medical Management of Rheumatoid Arthritis," Dr. Edward F. Hartung
"Blackache," Dr. Tully T. Blalock
"The Medical Management of Gout," Dr. Edward F. Hartung
10:30 a.m. Review of Exhibits—Exhibit Hall
11:15 a.m. Symposium on Arthritis continued:
"Physical Therapy and Rehabilitation in Arthritis, Strokes and Injuries, with Demonstrations," Dr. Donald A. Covalt
Questions to the Panel
12:00 Luncheon

Symposium on Stress

1:30 p.m. "A Practical Approach to Behavior Problems in Children," Dr. James Hughes
"Hormones and Susceptibility to Disease," Dr. Hans Selye
3:00 p.m. Intermission

3:15 p.m. Symposium on Stress continued: "Hormones and Susceptibility to Disease," continued, Dr. Hans Selye
4:30 p.m. Questions to the Panel
7:00 p.m. Cocktail Party
8:00 p.m. Banquet. Address by Dr. Malcom E. Phelps, President, The American Academy of General Practice. Entertainment by Mr. George Tonak and Miss Jane Ritter. Dancing.

Southern Medical Association Meets In Miami Beach, November 11-14

The Southern Medical Association will conduct its fifty-first annual meeting in Miami Beach on Nov. 11-14, 1957. The scientific programs will be held in the Miami Beach auditorium where registration and exhibits will also be located.

The scientific assembly is composed of 20 sections representing the major medical and surgical specialties. In addition to the programs of the sections, the following conjoint societies will also meet with the association: American College of Chest Physicians, Southern Chapter; The Association for Research in Ophthalmology, Inc., Southern Section; Southeastern and South Central Regional Committees of the College of American Pathologists; Southern Electroencephalographic Society; Southern Gynecological and Obstetrical Society; Southern Flying Physicians; and Student American Medical Association (Regional). The Southern Medical Association is the largest regional meeting conducted in the South. The Miami Beach sessions are expected to attract more than 5,000 registrants.

The association has arranged for a Housing Bureau at P. O. Box 1511, Miami Beach, for the convenience of physicians desiring to attend the meeting. Thirty hotels, conveniently located near the municipal auditorium, are cooperating with the Housing Bureau.

While the Southern Medical Association places major emphasis on a topflight scientific program, this is by no means the only attraction. The association will bring to Miami Beach 20 outstanding guest speakers from over the nation and from foreign countries. The program this year will present a great variety of color television, which will be presented on Monday, Tuesday and Wednesday and will be sponsored by several of the regular sections.

Another project of the association begun last year at the Washington meeting and known as the medical student representatives program will be a feature this year. A student representative



Dr. Donald F. Marion, of Miami, Chairman of the Greater Miami Committees on Arrangements for the Fifty-First Annual Meeting of the Southern Medical Association being held at Miami Beach.

from the University of Miami School of Medicine, the College of Medicine of the University of Florida, Medical College of Georgia, Emory University School of Medicine, Medical College of South Carolina and Medical College of Alabama will be the official guests of the association during the meeting. Other interesting highlights of the meeting will be the thirty-fourth annual golf tournament, a fishing rodeo, sessions of the Woman's Auxiliary and finally a postconvention tour to the Caribbean both by air and by ship.

Some of the features of the social aspects of the meeting will be more than a score of alumni and fraternity dinners; the President's luncheon on Monday, November 11; the Doctors' Day luncheon sponsored by the Auxiliary on Tuesday, November 12; and finally President's Night on Wednesday evening, November 13. President's Night will feature an address by the President, Dr. J. P. Culpepper Jr., of Hattiesburg, Miss. Another attraction of the Wednesday night program will be a salute to the Southern Medical

Association by "Grand Rounds." This national television feature will be screened in the ballroom during the President's Night program when a program titled "Frontiers of Coronary Artery Disease" will be presented.

Among alumni activities will be the dinner and social hour for graduates of Tulane University School of Medicine being held Tuesday evening, November 12, in the DiLido Hotel beginning at 6:30. A luncheon of the Theta Kappa Psi medical fraternity is also planned for Tuesday in the same hotel.

The success of the meeting is going to be due largely to the excellent work of the Greater Miami Committees on Arrangements of which Dr. Donald F. Marion is chairman. Dr. Marion and almost 300 other local physicians have been working tirelessly for the past several months in planning for the occasion.

The list of section officers of the association includes six prominent Florida physicians as follows: Dr. John T. Stage, Secretary, Section on Anesthesiology; Dr. Hugh B. Goodwin Jr., Secretary, Section on General Practice; Dr. Sherman B. Forbes, Chairman, Section on Ophthalmology and Otolaryngology; Dr. William A. D. Anderson, Vice-Chairman, Section on Pathology; Dr. Wesley S. Nock, Vice-Chairman, Section on Pediatrics; and Dr. Ralph F. Allen,† Vice-Chairman, Section on Proctology. In addition to these physicians, Dr. Joseph S. Stewart, Councilor from Florida, has taken an active part in the planning of the meeting and is serving as Chairman of the Executive Committee on Arrangements. Dr. Walter C. Jones, a former president of the association and now a member of the Board of Trustees, is serving as Chairman of the Advisory Committee.

†Deceased, Aug. 9, 1957.

OTHERS ARE SAYING

The Florida Medical Foundation

This organization was founded September 24, 1956 as a non-profit group with the object of enhancing the health and medical care of the people of our state by fostering medical education, disseminating scientific knowledge to the physician and to the public. They plan to promote the principles of medical ethics and in defeating unmerited charge of professional malpractice; encouragement of medical research and provide needed assistance to members of our association and of perhaps greatest importance, the furnishing of financial aid to medical students needing assistance.

Each year each of us should and probably does send to his medical school a check from ten to one hundred dollars to further the education in his alma mater for each of us know that without this aid their school would no longer be the top ranking medical school in the country. Our pride and part of our ego (if they may be separated) stems from the ability to say that I graduated from "the" medical school.

To attract donations to the Universities many programs such as publicity, class competition and other methods for raising the necessary money have been established. Some have even allowed one's donation to be applied to a scholarship for one's son or daughter, should they at a later year be so fortunate as to attend "the" medical school. All considered, these programs are wholesome and vital to the American way of life.

Any foundation that is to obtain any mark of approval must handle considerable quantities of money, for by this reputation they will soon become known. If large industrial groups should want to establish a scholarship in our state they would first look for a well qualified organization to do this work.

If all the money that we send to our Alma Mater could funnel through the Florida Medical Foundation we would then have a well functioning organization that could handle quantities of money and this organization could then attract outside capital to our state and in time they could establish several medical scholarships, carry on the objects of the Foundation and ultimately would result in a great boon to our society.

The Florida Medical Foundation is unknown. It needs publicity, advertisement and to generally let itself be known. Ten dollars from each of our physicians funneled through the group would soon put this organization on the map.

Why not a flat envelope sheet in each Florida Medical Journal with an addressed side and a check sheet side so that we the physicians could tear it out, mark the check sheet, fold it and deposit his check within the envelope and then our check to "the" university is on its way through the Florida Medical Foundation.

The Bulletin
Sarasota County Medical Society
July, 1957.

STATE NEWS ITEMS

The Seventeenth Annual Convention of the Gulf Coast Clinical Society is being held in the Buena Vista Hotel at Biloxi, Miss., October 17-18, according to announcement by Dr. James R. Foster, Secretary-Treasurer.

Guest speakers appearing on the program include Dr. Eugene A. Stead Jr., Duke University School of Medicine, Durham; Dr. William Parsons, University of Virginia Department of Medicine, Charlottesville; Dr. Richard E. Wolf, Children's Hospital, Cincinnati; Dr. Walter H. Sheldon, Emory University School of Medicine, Atlanta; Dr. Robert A. Knight, Campbell's Clinic, Memphis; Dr. Jacob P. Greenhill, Chicago, and Dr. Arthur L. Kretchmar, Oak Ridge Institute, Oak Ridge, Tenn.

The 22nd Annual Convention of the American College of Gastroenterology will be held at The Somerset in Boston, Mass., October 21-23, and the Annual Course in Postgraduate Gastroenterology the three following days.

EMORY UNIVERSITY SCHOOL OF MEDICINE
Atlanta, Georgia
Announces
SIX DAYS
of
CARDIOLOGY
(January 13-18, 1958)

Major Problems of Heart Disease will be discussed by Members of the Emory University Faculty and the following visitors:

A. Carlton Ernstene, M.D., Chairman, Division of Medicine, Cleveland Clinic, Cleveland, Ohio
Dwight E. Harken, M.D. Assistant Clinical Professor of Surgery, Harvard Medical School; Surgeon, Peter Bent Brigham Hospital; Chief of Department of Thoracic Surgery, Mount Auburn and Malden Hospitals, Boston, Mass.
Helen B. Taussig, M.D., Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine; Director of the Children's Heart Clinic of the Harriet Lane Home, The Johns Hopkins Hospital, Baltimore, Md.
Eugene A. Stead, M.D., Professor and Chairman, Department of Medicine, Duke University School of Medicine, Durham, N. C.
Ancel B. Keys, M.D., Professor of Medicine, University of Minnesota; Director of the Laboratory of Physiological Hygiene, University of Minnesota School of Public Health, Minneapolis, Minn.
Edward S. Orgain, M.D., Professor of Medicine, Duke University School of Medicine; Director, Cardiovascular Disease Service, Duke Hospital, Durham, N. C.
E. Grey Dimond, M.D., Professor and Chairman of the Department of Medicine; Director of the Cardiovascular Laboratory, University of Kansas Medical Center, Kansas City, Kansas.
Gene H. Stollerman, M.D., Associate Professor of Medicine, Northwestern University, Chicago, Ill.

Tuition fee: $100.00
Write: Postgraduate Teaching Program, Emory University School of Medicine, 69 Butler Street, Atlanta 3, Georgia

Many individual papers are to be presented during the Convention, and in addition there will be three panel discussions. Moderators for the Annual Course will be Dr. Owen H. Wangensteen of Minneapolis and Dr. I. Snapper of Brooklyn.

Dr. Fred E. Manulis of Palm Beach is Governor for the state of Florida for the American College of Gastroenterology.

The Annual Meeting of the Florida Division of the American Cancer Society is being held in the Roosevelt Hotel at Jacksonville October 19-20. Dr. William C. Roberts of Panama City, President of the Florida Medical Association, has accepted an invitation to appear on the program.

Dr. Robert T. Spicer of Miami is serving as President of the Miami-Dade County Chamber of Commerce. He is the first physician to be elected to this position.

Mr. W. Joe Stansell has been assigned as Blue Cross-Blue Shield Professional Relations representatives to the Florida Medical Association's Advisory Committee to Blue Shield. The Committee is also known as the "Committee of Seventeen."

Assignment of Mr. Stansell to the position is in accordance with a request of the Committee in its annual report to the Association.

A Sectional Meeting of the American College of Surgeons will be held January 16-18 in the Hotel Heidelberg at Jackson, Miss. Topics will include Complications of Abdominal Surgery, Chemotherapy, Metastasis and Limitations of Surgery for Cancer, Errors in Management of Fractures, Pediatric Surgery, and Management of Multiple Injuries.

Dr. Milton C. Foard, who has been serving a residency in internal medicine at the McGuire Veterans Administration Hospital in Richmond, Va., has become associated with Dr. Geoffrey H. Binneveld at Leesburg.

The New York University-Bellevue Medical Center Postgraduate Medical School has announced courses in Medicine, Obstetrics and Gynecology, Ophthalmology, Otorhinolaryngology, and Pediatrics to be given or started during the month of November. Information about the in-

(Continued on page 390)

NO KNOWN CONTRAINDICATIONS

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permits high dosage, more effective diuresis in more patients

The low incidence of side action with Rolicton (brand of amisometradine) permits high dosage, extending the range of effective diuresis to a greater number of patients than was previously possible.

Laboratory studies demonstrate that Searle's new oral diuretic, Rolicton, causes positive diuresis with an essentially balanced excretion of water, sodium and chlorides.

Settel[1] studied the effect of Rolicton in forty-seven patients and found no serious side effects. Assali, who observed the action of Rolicton in five patients with severe toxemia of pregnancy, states[2] that side actions are essentially nonexistent. Side actions of such low incidence, together with its diuretic efficacy, suggest a high order of usefulness for Rolicton.

One tablet of Rolicton, b.i.d., is usually adequate to maintain patients free of edema after the first day's dosage of four tablets. Some patients respond well to one tablet daily. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

1. Settel, E.: Rolicton® (Aminoisometradine), a New, Nonmercurial Diuretic, Postgrad. Med. *21*:186 (Feb.) 1957.
2. Assali, N. S.: Personal communication, May 28, 1956.



Normal glomerulus, shawing arteriale musculature, glamerular epithelial padacytes, and "epitheloid" muscle cells af vas efferens.

SEARLE

INTRAVENOUS Compatible with common IV fluids. Stable for 24 hours in solution at room temperature. Average IV dose is 500 mg. given at 12 hour intervals. Vials of 100 mg., 250 mg., 500 mg.



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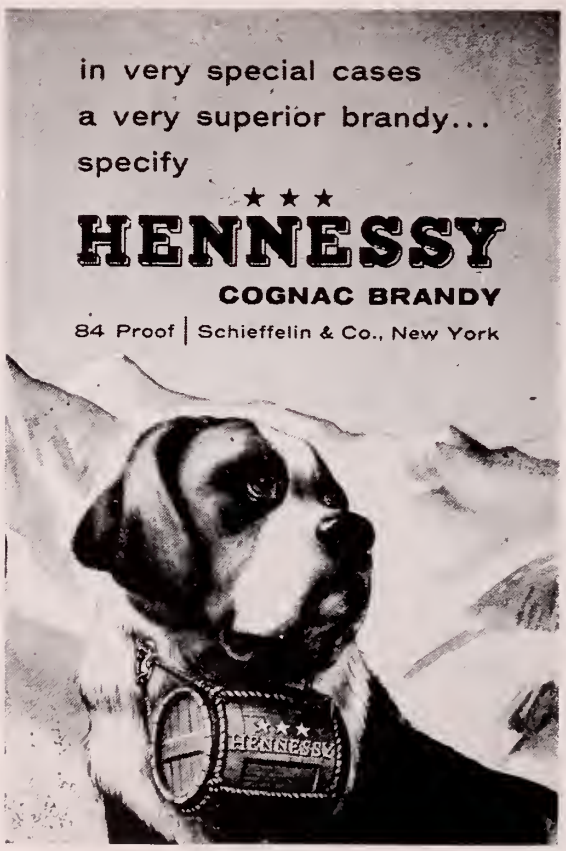
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(Continued from page 386)

dividual courses may be obtained by writing to the School at New York City.

Dr. Augustus E. Anderson Jr., of Jacksonville has been awarded a grant by the National Institutes of Health for the study of pulmonary fibrosis.

Dr. William C. Roberts of Panama City, President of the Florida Medical Association, was a principal speaker at the Fall Board Meeting and Conference of the Woman's Auxiliary to the Florida Medical Association held early in October at Pensacola.

Dr. Richard A. Henry of Brooksville has been presented a plaque by the Withlacoochee District of the Gulf Ridge Council, Boy Scouts of America, for his continued work with Scouts in the Brooksville area.

Drs. Myron L. Habegger of Rockledge and James F. Speers of Titusville were members of a panel which discussed "Medical Service" at an industrial conference held late in August at Eau Gallie. The conference on "How to Adjust to Rapid Industrial Growth" was conducted by the General Extension Division of the University of Florida and was co-sponsored by the city of Eau Gallie, the Florida Power and Light Co. and the Florida Development Commission.

Dr. Habegger is President of the Brevard County Medical Society and Dr. Speers is health officer for Brevard county.

Dr. William C. Roberts of Panama City, President of the Florida Medical Association, was principal speaker at a recent luncheon meeting of the Rotary Club of that city.

The third world tour, postgraduate clinical course, sponsored by the International College of Surgeons begins at San Francisco October 20 and ends at New York December 7. Lectures and clinical demonstrations have been arranged in Hong Kong, the Philippines, Thailand, India Turkey and Greece. Detailed information may be obtained from the International Travel Service, Inc., Palmer House, Chicago.

The annual interim meeting of the Florida Urological Society was held September 21 at the

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1. Hodges, F. T.: GP, *14*:86, Nov., 1956.

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Yankee Clipper in Fort Lauderdale. The program included an address by Dr. Edward Ray of Lexington, Ky., on "Transurethral Resection" and discussions on subjects relating to bladder obstruction led by Drs. Hilbert A. P. Leininger, William A. Van Nortwick and Robert Webster. Dr. W. Dotson Wells of Fort Lauderdale is president of the specialty group.

Drs. Hugh A. Carithers and J. Champneys Taylor of Jacksonville served on the faculty of the Southern Pediatric Seminar held recently at Saluda, N. C.

A Medico-Legal Institute sponsored by the Florida Medical Association and The Florida Bar is being held in the George Washington Hotel at Jacksonville November 22-23. The program begins at 9:00 a.m. and ends at noon the following day.

Tentatively scheduled for discussion are "Relationship of Cancer and Trauma;" "Relationship of Trauma and Strain on the Cardiovascular System;" "Electromyograph as an Aid in Evaluating Nerve and Muscle Injury;" "Crash Syndrome;" "Whiplash;" "Post Concussion Syndrome;" "Back Injury—Its Cause and Sequelae," and "Disability Evaluation."

Dr. Douglas R. Murphy of Venice has been elected president of the Rotary Club of that city. Dr. Murphy has been a member of the Club for six years.

The annual scientific meeting of the Florida Crippled Children's Commission and its corresponding voluntary organization, Florida Society for Crippled Children, is being held at St. Petersburg, October 11, in the Suwannee Hotel. Principal speakers include Dr. Carlton Dean, Director, Michigan Crippled Children's Commission, Lansing; Col. Maurice Fletcher, MC, Chief, Army Prosthetic Research Laboratory, Washington, D. C., and Dr. Charles H. Franz, Chairman, Children's Prosthetic Committee, National Research Council, Grand Rapids, Mich.

The Part I Examinations of the American Board of Obstetrics and Gynecology are to be held in various parts of the United States and Canada on Thursday, Jan. 2, 1958 at 2:00 p.m. Current Bulletins outlining present requirements may be obtained from Dr. Robert L. Faulkner, Secretary, American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

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COMPONENT SOCIETY NOTES

Alachua

The Alachua County Medical Society has paid 100 per cent of its state dues for 1957.

Dade

Dr. William C. Roberts, of Panama City, President of the Florida Medical Association, will be principal speaker at the October meeting of the Dade County Medical Association.

DeSoto-Hardee-Highlands-Glades

The DeSoto-Hardee-Highlands-Glades County Medical Society has paid 100 per cent of its state dues for 1957.

Escambia

The Escambia County Medical Society has paid 100 per cent of its state dues for 1957.

Pinellas

The September meeting of the Pinellas County Medical Society was the first section of the annual meeting which is scheduled for October 7. Nominations for officers and to fill vacancies on the Board of Governors were made from the floor and will be held open until the annual meeting.

Orange

Dr. Samuel M. Day, of Jacksonville, Secretary-Treasurer of the Florida Medical Association, was principal speaker on the program for the September meeting of the Orange County Medical Society.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Dyal, John A. Jr., Perry
Gair, David R., Miami
Major, James M., Pensacola
Martin, Cornelia R. C., Gainesville
Martinez, Gerardo H., Miami
May, Lonnie C. Jr., Key Biscayne
Nardone, Robert R., South Miami
Szawlowski, Matthew W., Titusville
Weeks, Clarke B. Jr., Plant City



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WANTED: General surgeon desires location alone or with associate. Board eligible, married, Florida license. Prefer smaller city. Write 69-238, P. O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner to join three man group in clinic practice in Miami. Florida license necessary. Adequate salary first, followed by partnership. Give details first letter. Write 69-241, P. O. Box 2411, Jacksonville, Fla.

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WANTED: A General Practitioner, an Ophthalmologist, an Otolaryngologist to associate with group in Brevard County. Florida license necessary. Write age, training, medical experience and references. Write Box 368, Rockledge, Fla.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Jonas Carron, of Tampa, announce the birth of a son, Lewis Marks, on June 22, 1957.

Dr. and Mrs. James K. Moss, of Jacksonville, announce the birth of a daughter, Ann Carolyn, on July 14, 1957.

Dr. and Mrs. James D. Beeson, of Jacksonville, announce the birth of a son, Richard Carl, on Aug. 5, 1957.

Deaths — Members

Allen, Ralph F., Coral Gables	August 9, 1957
Lerner, Lee W., Miami	July 4, 1957
Price, Cleveland J., Alford	August 23, 1957
Edmunds, C. Harold, Miami	August 26, 1957

Deaths — Other Doctors

Dalpe, William G., Los Angeles, Calif.	August 7, 1957
Drennen, Earle, Birmingham, Ala.	July 4, 1957
Ehrlich, Simon D., Hollywood, Fla.	May 7, 1957
Gibson, Ira M., Valdosta, Ga.	March 31, 1957
McElroy, Joseph D., Atlanta, Ga.	April 26, 1957
Peel, George T., Anderson, S. C.	July 16, 1957
Spooner, Doster S., Pahokee, Fla.	July 21, 1957
Jordan, Thomas C. Jr., Lakeland, Fla.	August 8, 1957

Medical Officer Returned

Dr. Robert G. Rosser Jr. who entered military service on May 8, 1955 was released from active duty on May 8, 1957 with the rank of major. U. S. Army. His address is 507 Delannoy Avenue, Cocoa, Fla.

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OBITUARIES

Adelbert F. Schirmer

Dr. Adelbert F. Schirmer of Orlando died in that city on April 4, 1957. He was 51 years of age.

A native of Massachusetts, Dr. Schirmer was born in Boston on April 29, 1905. He entered Northeastern University in his native city in 1926 and was graduated in 1930 with a degree in engineering. After pursuing that profession for three years, he realized that his real interest was in medicine. Accordingly, upon completion of his premedical training at Tufts College, also in Boston, he continued his medical training at Tufts College Medical School, where he received the degree of Doctor of Medicine in 1939. After serving an internship in Newton Lower Falls, Mass., he accepted a commission as a lieutenant in the Navy in July 1940. Assigned to the U.S.S. Enterprise in 1941, he saw much action in the South Pacific aboard this famous carrier. He was given pilot training in 1944 and, upon earning his wings, was transferred to the Air Transport Evacuation Squadron No. 1. In that unit he saw duty in the naval operations at Guam and Okinawa. He was awarded the presidential unit citation, the Navy unit commendation and commendation from Admiral Nimitz for his duty on the Enterprise. In January 1946, he was released from active duty with the rank of commander.

Dr. Schirmer entered the practice of his specialty of anesthesiology in Orlando in 1947 and became the first anesthesiologist at the Orange Memorial Hospital. Until the time of his death he served as Director of the Department of Anesthesiology there. It was through his efforts that the specialty of anesthesiology made its imprint on the practice of medicine in Central Florida. Locally, he was active in the community and in his church.

A member of the Orange County Medical Society, Dr. Schirmer served as a delegate to the Florida Medical Association from that body for several years. In addition to active membership in his county and state societies during the 10 years of his affiliation, he was a member of the American Medical Association, the Florida Society of Anesthesiologists, the American Society of Anesthesiologists and the International Anesthesia Research Society.

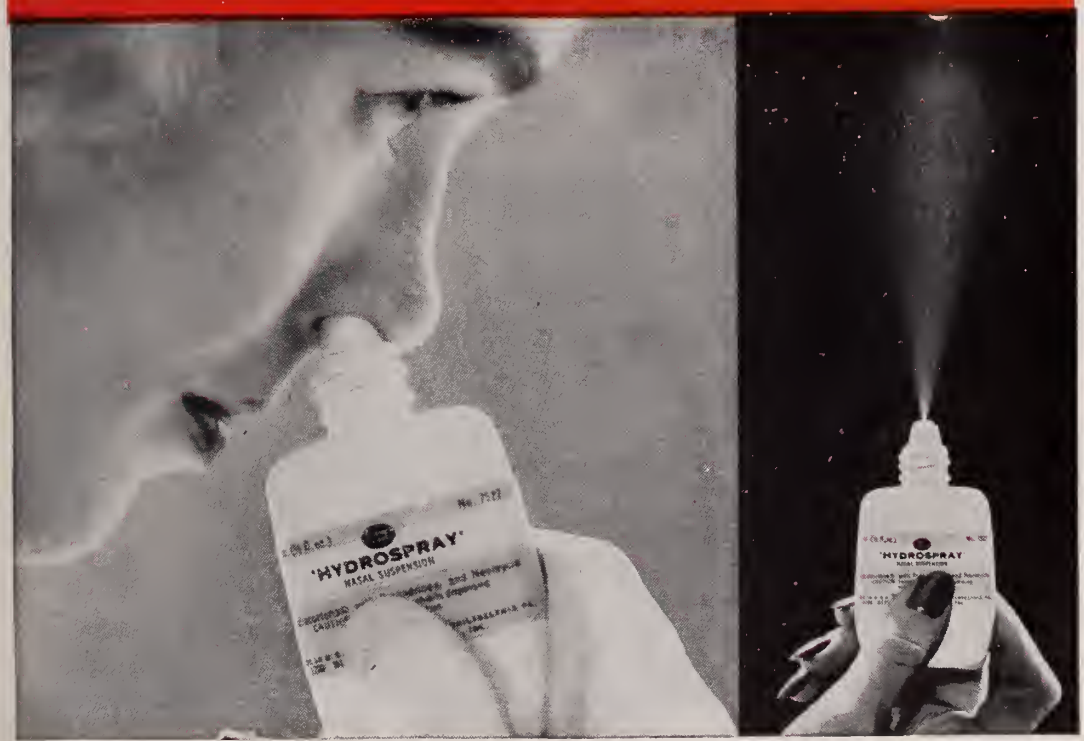


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REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60:431, Oct. 1954.

Surviving are the widow, Mrs. Dorothy M. Schirmer; a son, Richard, and a daughter, Emily.

William Jesse Lancaster

Dr. William Jesse Lancaster died at his home in Tampa on April 26, 1957, following a long illness. He was 68 years of age.

Dr. Lancaster was born in Flovilla, Ga., in 1888, and received his elementary, academic and professional education in his native state. He attended the schools of Monroe County and in 1904 received the Bachelor of Arts degree from Banks-Stevens Institute. For his medical training he entered the Atlanta School of Medicine, now Emory University School of Medicine, and was awarded the degree of Doctor of Medicine in 1911. He interned at Grady Hospital in Atlanta, New York Lying In Hospital in New York City, and Allen Sanitarium in Milledgeville, Ga. He became the first resident surgeon at Grady Hospital.

In 1911, Dr. Lancaster came to Florida and served as surgeon for the phosphate mines at Mulberry. Two years later he made Tampa his home and was associated with the late Dr. John S. Helms from 1913 until he entered private practice in 1916. He was chief surgeon for the P. & O. Steamship Company for over 20 years and also for the Tampa Union Station Company. He was a U. S. Public Health officer and surgeon in charge of Florida's first veterans' hospital. During World War I, he served in the Army Medical Corps with the rank of lieutenant colonel.

In 1934, Dr. Lancaster was appointed chief surgeon, medical director and superintendent of the relief department of the Atlantic Coast Line Railroad, with headquarters in Wilmington, N. C. While serving in this capacity for eight years, he was at one time chairman of the medical and surgical section of the American Association of Railroads, which includes Canada and Mexico. In 1942, he resigned from his important post with the Coast Line because of ill health and returned to Tampa.

Dr. Lancaster enjoyed the distinction of being the only American physician to receive the certificate of merit from the King of Spain for his work in the Centro Asturiano hospitals in Tampa and Havana, Cuba. Locally, he was a member of the staff of the Tampa General Hospital and a former director of surgery and chief

(Continued on Page 404)

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Phenacetin	120 mg.
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Salicylamide	150 mg.
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Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
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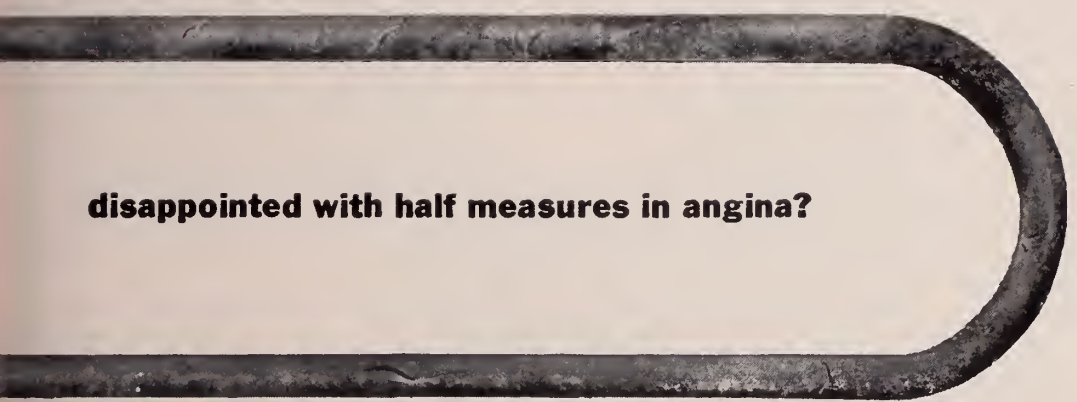
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1. Russek, H. I.: J. Am. Geriat. Soc. *4*:877 (Sept.) 1956.

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(Continued from page 400)

of staff there. He was also a member of the staff of St. Joseph's Hospital.

Prominent in the social and civic life of the community, Dr. Lancaster was a past potentate of Egypt Temple Shrine and a York Rite Mason; he was also a member of Strict Observance Lodge 18, F. & A. M., at Forsyth, Ga. He was a life member of the Tampa Exchange Club and the Elks Lodge, and he held membership in American Legion Post No. 5. He was a former member of the Tampa Yacht and Country Club, the Palma Ceia Golf and Country Club, and Ye Mystic Krewe of Gasparilla. His church affiliation was with the Trinity Methodist Church of Wilmington, N. C.

Dr. Lancaster was a life member of the Hillsborough County Medical Association. He also held life membership in the Florida Medical Association, having been a member for 43 years. He was a fellow of the American Medical Association, and a member of the Southern Medical Association, the Southeastern Surgical Congress, the American Academy of General Practice, the New York Academy of Science, and the American Association for the Surgery of Trauma.

Surviving are the widow, Mrs. Jean Lunden Lancaster, of Tampa; two daughters, Mrs. Allen Trask, of Wrightsville Beach, N. C., and Mrs. Howard Sparrow, of Florence, S. C.; a sister, Mrs. C. M. Durgin, and a brother, G. T. Lancaster, both of Tampa; five grandchildren, and several nieces and nephews.

Joseph W. Eaton

Dr. Joseph W. Eaton of St. Petersburg met accidental death by drowning on April 23, 1957. He was 49 years of age.

Dr. Eaton was born in Arlington, Mass., on Nov. 25, 1907. He received his premedical education at the University of North Carolina and engaged in postgraduate work at Harvard University. He was awarded the degree of Doctor of Medicine by McGill University Faculty of Medicine, Montreal, Canada, in 1935. After completing an internship at Monmouth Memorial Hospital in Long Branch, N. J., he entered the private practice of medicine as a general practioner in 1936 in Manchester, N. H., and continued to



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practice there until 1950. He was a member of the staff at the Elliot, Sacred Heart and Hillsboro County hospitals in Manchester. He was a member of the Grace Episcopal Church of Manchester and of Bible Lodge, F. & A. M., of Goffstown, N. H.

During 1950-1951, Dr. Eaton served as a resident in anesthesiology at the Baroness Erlanger Hospital in Chattanooga, Tenn., and the following year completed a residency in this specialty at Charity Hospital in New Orleans. He then spent one year in private practice in New Orleans before moving to St. Petersburg in 1955. In that city he was a member of the staff of Mound Park, St. Anthony's and Crippled Children's hospitals, and was president of the St. Petersburg New Voice Laryngectomy Club.

Dr. Eaton was a member of the Pinellas County Medical Society, the Florida Medical Association and the American Medical Association. He also held membership in the Hillsboro County (New Hampshire) Medical Society, the New Hampshire Medical Society, the American Society of Anesthesiologists and the Florida Society of Anesthesiologists.

Surviving are the widow, Mrs. Hazel Alma Eaton, of St. Petersburg; one son, Joseph W. Eaton Jr., of Intervale, N. H.; two daughters, Mrs. Mary Garland, and Mrs. Ivy Gile, both of Conway, N. H.; and one brother, Chester C. Eaton, of Manchester, N. H.

George Edwin Beckman

Dr. George Edwin Beckman of Jacksonville died in a local hospital on March 27, 1957. He was 77 years of age.

Born in Charleston, S. C., on Oct. 20, 1879, Dr. Beckman was educated in his native state. He was a graduate of the Charleston High School and was graduated from the University of South Carolina College of Pharmacy in 1906 and the University of South Carolina Medical College in 1909. After completing an internship at Roper Hospital in Charleston, he engaged in postgraduate work on anesthesia in New York. He was a member of the Phi Chi medical fraternity.

Dr. Beckman entered the practice of medicine in Jacksonville and practiced there for 40 years prior to his retirement a few years ago. His specialty was anesthesiology, and in 1939 he was

(Continued on page 417)



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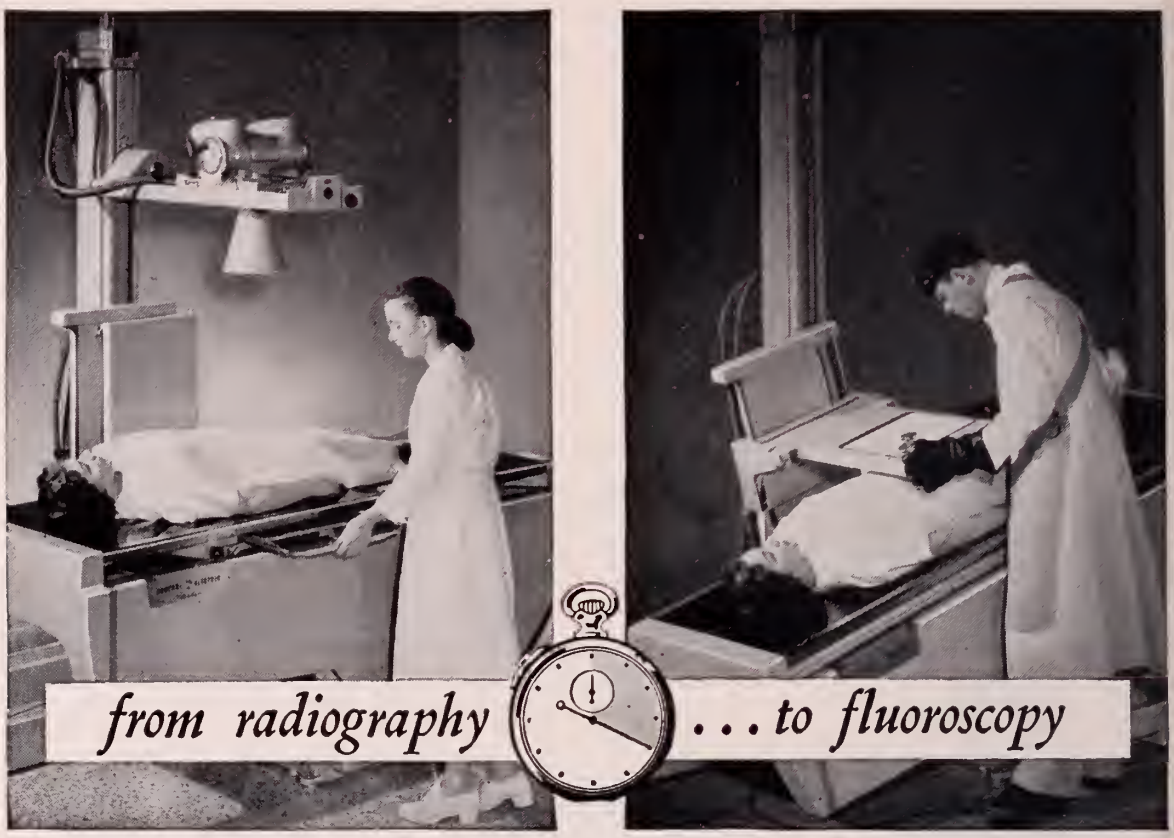
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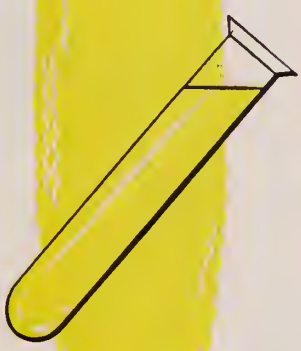
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CORN OIL is a Prime Source of UNsaturated Fatty Acid

Numerous clinical studies emphasize its efficacy in the reduction and control of serum cholesterol levels





Physicians are quite aware of the rapidly growing appreciation of the role of dietary lipids in health and disease. Accumulating metabolic studies throughout the world indicate that serum cholesterol levels may be influenced more by the *kind* than by the *amount* of the dietary fat.

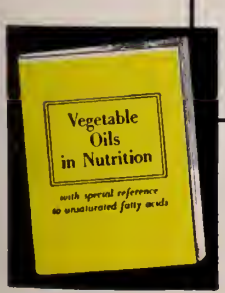
Unsaturated fats tend to depress serum cholesterol levels in many patients, whereas saturated fats may have the opposite effect. Medical references on this subject, as well as other findings concerning unsaturated fatty acids in nutrition, may be found in the book, "Vegetable Oils in Nutrition."

Mazola Corn Oil is an excellent source of *un*saturated fatty acids...85% of its component fatty acids are unsaturated...average values being 55% linoleic acid, 30% oleic acid. Mazola is unadulterated corn oil in its natural form...*not* flavored, *not* blended, *not* hydrogenated. Well tolerated, easily digested, readily absorbed, Mazola is also an excellent carrier for fat soluble vitamins.

Mazola Corn Oil is widely used for salad dressings, in frying, cooking and baking... and thus may be included palatably in great variety as a replacement for part of the daily fat intake.

COMPARATIVE COMPOSITIONS OF FOOD FATS AND OILS

Fat	Fatty Acids as Percentage of Total Acids									Iodine Value	
	Saturated		Oleic		Linoleic		Linolenic		Arachidonic		
	Ave.	Range	Ave.	Range	Ave.	Range	Ave.	Range	Ave.	Average	Range
Butter	—	46-48	—	—	4.0	—	1.2	—	0.2	—	26-42
Coconut oil	—	75-88	—	5-8	—	1.0-2.5	—	—	—	—	7-10
Corn oil	13	11-15	—	23-40	56	46-66	—	0.0-0.6	—	126	113-131
Cottanseed oil	26	21-30	27	22-36	47	34-57	—	—	—	105	90-117
Lard	43	—	46	—	10	15.6	0.5	—	0.5 (2.1)	—	53-77
Linseed oil	—	6-12	—	13-31	—	10-27	—	30-64	—	—	170-204
Margarine	23	15-23	62	59-77	5.8	5-11	—	0.1-0.9	0	81	74-85
Olive oil	—	8-16	—	53-86	—	4-20	—	—	—	—	80-88
Peonut oil	17	14-22	54	44-65	29	20-37	—	—	—	98	90-102
Shortening	25	17-45	62	43-79	5	3-12	—	0.2-0.6	0-0.5	78	59-80
Soybeon oil	15	11-18	25	18-58	55	28-62	5.1	0.3-10	—	130	100-143
Tallow (beef)	53	—	42	—	4	5.3	0.5	—	0.5	—	40-48



Iodine numbers are an accepted measure of the degree of unsaturation of vegetable oils.

TO PHYSICIANS interested in the study and management of high cholesterol blood levels, this most recent monograph will provide helpful information. It is free on request. Write to: Corn Products Refining Company, 17 Battery Place, New York 4, N. Y.

CORN PRODUCTS
REFINING COMPANY
17 Battery Place,
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For Complete Nutrition



Feeding Directions

BAKER'S MODIFIED MILK (Liquid)

NEWBORN INFANTS (Hospital)—1 part Baker's to 2 parts cool water.

FIRST WEEK AT HOME — 1 part Baker's to 1½ parts cool water.

AFTER FIRST WEEK AT HOME — 1 part Baker's to 1 part cool water.

INFANTS THRIVE ON BAKER'S.
And for sound reasons:

Baker's contains all requirements for complete infant nutrition . . . It is available as an easy-to-prepare Liquid and as a Powder, the latter particularly adaptable for feeding prematures and for complemental and supplemental feedings . . .

Both forms are easy to prescribe and prepare in hospital and home . . . Both cost less than a penny per ounce of formula, are furnished gratis to hospitals for your use.



Liquid Powder

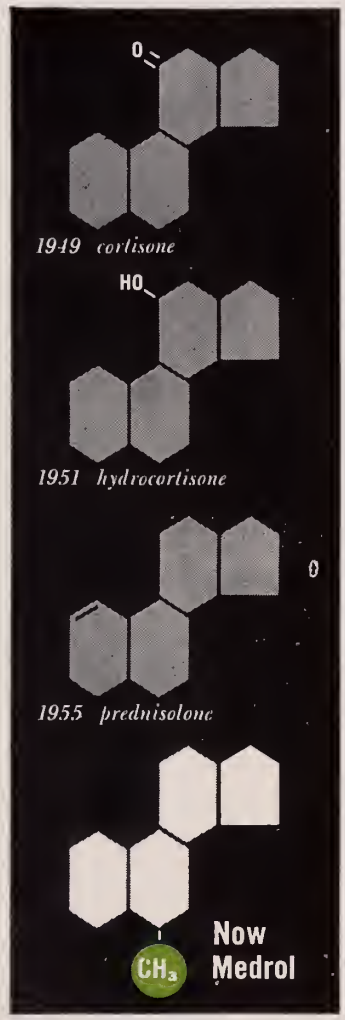
BAKER'S MODIFIED MILK

THE BAKER LABORATORIES, INC.

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The
Upjohn Company
announces
a major
corticosteroid
improvement



minor chemical changes can mean major therapeutic improvements

Medrol*

The most efficient of all anti-inflammatory steroids

- Lower dosage (⅓ lower dosage than prednisolone)
- Better tolerated (less sodium retention, less gastric irritation)

Supplied: Tablets of 4 mg., in bottles of 30 and 100.

*TRADEMARK FOR METHYLPREDNISOLONE, UPJOHN

For complete information, consult your Upjohn representative, or write the Medical Department, The Upjohn Company, Kalamazoo, Michigan.

Upjohn

New Chemotherapy

ARALEN® in RHEUMATOID ARTHRITIS

Extensive studies of rheumatoid arthritis and related collagen diseases—in this country and abroad—have shown the antimalarial Aralen phosphate to be highly effective and well tolerated in a large percentage of patients.

Clinical Results with Aralen in Rheumatoid Arthritis

Author	No. of Cases	Major Improvement	Minor Improvement	No Effect
Haydu[1]	28	22	5	1
Rinehart[2]	25	12	4	9
Freedman[3]	50	43	3	4
Bagnall[4]	108	77	12	19
Bruckner[5]	36	32	0	4
Cohen and Calkins[6]	22	17	3	2
Scherbel et al.[7]	25	9	8	8
Total	294	212 (72%)	35 (12%)	47 (16%)

- Success dependent upon persistent treatment
- Often of benefit where other agents have failed
- Remissions on therapy well maintained
- Remission of 3 to 12 months possible even if treatment is interrupted
- Tachyphylaxis not evident

GENERAL EFFECTS:

- Patient feels better
- Patient looks better
- Exercise tolerance increases
- Walking speed and hand grip improves

LABORATORY EFFECTS:

- E. S. R. may fall slowly
- Hemoglobin level may gradually rise

ANALGESICS AND STEROIDS:

- Requirements usually reduced or eliminated

JOINT EFFECTS:

- Pain and tenderness relieved
- Mobility increases
- Swellings diminish or disappear
- Muscle strength improves
- Rheumatic nodules may disappear
- Even severe or advanced deformity may improve
- *Active* inflammatory process usually subsides
- Joint effusion may diminish

DOSAGE:

Aralen is cumulative in action and requires four to twelve weeks of administration before therapeutic effects become apparent.

Latest information indicates that an initial dose of 250 mg. of Aralen phosphate is preferable to the higher doses sometimes recommended. However, If side effects appear, withdraw Aralen for several days until they subside. Reinstate treatment with 125 mg. daily and, if well tolerated, increase to 250 mg. The usual maintenance dose is 250 mg. daily.

New Chemotherapy

INDICATIONS:

- Rheumatoid arthritis, acute or chronic —with or without adjunctive therapy.
- Spondylitis
- Arthritis associated with lupus erythematosus or psoriasis

THEORY OF ACTION:

Aralen appears to suppress or induce remission of rheumatoid inflammatory processes by inhibiting adenosinetriphosphatase.

HOW SUPPLIED:

Aralen phosphate: 250 mg. tablets in bottles of 100 and 1000.
125 mg. tablets in bottles of 100.

Tolerance:

Aralen is usually well tolerated. Toxic effects are usually mild and to date have been transitory in nature, disappearing completely either on continuance or cessation of therapy or on reduction in dosage.

Gastrointestinal disturbances (e.g. nausea, rarely vomiting, diarrhea, abdominal cramps, anorexia) are frequent manifestations of intolerance. Temporary blurring of vision (due to interference with accommodation) is also relatively frequent.

Pleomorphic skin eruptions (e.g. lichenoid, maculopapular, purpuric), although generally mild, may preclude the use of an optimum dosage schedule. If a skin reaction persists on a reduced dosage schedule, or recurs after reinstitution of treatment with gradually increasing doses, discontinue Aralen till the lesion again disappears and consider resuming treatment with Plaquenil® (brand of hydroxychloroquine).

Less frequently transitory vertigo, headache, lassitude, or neurological disturbances, such as nervousness, irritability, emotional change, and nightmares have been reported. Instances of unexplained slight gradual weight loss as the patient's general health and arthritic condition improved have been mentioned. Occasional instances of bleaching (depigmentation) of the hair have been described.

Although an occasional instance of leukopenia, with normal differential count, has been reported (WBC about 3000), it has not proved troublesome because it has always been reversible on discontinuance, or diminution of the dose. Even spontaneous reversal may occur while full dosage is maintained.

Caution:

Aralen is known to concentrate in the liver and, although hepatic damage has never been reported, the drug should be used with caution in the presence of liver disease. In the presence of severe gastrointestinal, neurological, or blood disorders, the drug should be used with caution or not at all. If such disorders occur during the course of therapy, the drug should be discontinued. Concomitant use of gold or phenylbutazone with Aralen should be avoided because of the tendency of these agents to produce drug dermatitis.

Clinical Comments:

Of fifty patients receiving Aralen therapy, "43 have become really well; that is, they have no stiffness, and any pain that occurs can reasonably be attributed to use of joints affected by secondary degenerative changes. They have no evidence of joint inflammation, but may have a raised erythrocyte sedimentation rate. They have little or no need for analgesics." *Freedman*[3]

"One hundred and twenty-five private patients have been carefully followed clinically and haematologically while receiving well over 200 patient-years of chloroquine [Aralen] therapy. The results are considered good in 70%, one-half of these cases being in remission. Improved work performance, sedimentation rate, and hemoglobin levels paralleled the major objective gain in this 70%. 90% of them remained on chloroquine [Aralen] therapy, half for more than two years. Classical peripheral rheumatoid arthritis, spondylitis, arthritis of juvenile onset, and rheumatoid disease with psoriasis, all appeared to respond about equally well.

"It is suggested that chloroquine comes closer to the ideal for long-term, safe, control of rheumatoid disease than any other agent now available." *Bagnall*[4]

"Out of the 36 rheumatoid arthritis cases we treated . . . favorable results were obtained in 32 cases. *Bruckner et al.*[5]

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3. Freedman, A.: Chloroquine and rheumatoid arthritis, a short-term controlled trial, *Ann. Rheum. Dis.* 15:251, Sept., 1956.
4. Bagnall, A.W.: The value of chloroquine in rheumatoid disease, a four year study of continuous therapy, read at the Ninth International Congress on Rheumatic Diseases in Toronto, Canada, June 23-28, 1957.
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Winthrop LABORATORIES
NEW YORK 18, N. Y.

If
Monilial
overgrowth
is a factor

ACHROSTATIN*V

Tetracycline (phosphate-buffered) and Nystatin

Combines ACHROMYCIN V with NYSTATIN

ACHROSTATIN V combines ACHROMYCIN† V . . . the new rapid-acting oral form of ACHROMYCIN† Tetracycline . . . noted for its outstanding effectiveness against more than 50 different infections . . . and NYSTATIN . . . the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients who are prone to monilial overgrowth during a protracted course of antibiotic treatment.

supplied:
ACHROSTATIN V CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin.

dosage:
Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

*Trademark
†Reg. U. S. Pat. Off.

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N. Y.



For anxiety, tension and muscle spasm in everyday practice.

- well suited for prolonged therapy
- well tolerated, relatively nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness

RELAXES BOTH MIND AND MUSCLE

WITHOUT IMPAIRING MENTAL OR PHYSICAL EFFICIENCY



Miltown®

tranquilizer with muscle-relaxant action

2-methyl-2-**n**-propyl-1,3-propanediol dicarbamate — U. S. Patent 2,724,720

Supplied: 400 mg. scored tablets
200 mg. sugar-coated tablets

Usual dosage: One or two 400 mg. tablets t.i.d.

Literature and samples available on request

WALLACE LABORATORIES, *New Brunswick, N. J.*

MILTOWN · THE ORIGINAL MEPROBAMATE · DISCOVERED AND INTRODUCED BY WALLACE LABORATORIES

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AN IMPORTANT ADVANCE IN MENOPAUSAL THERAPY

Because it replaces *half* control with *full* control.

Because it treats the *whole* menopausal syndrome.

Because *one* prescription manages *both* the psychic and somatic symptoms.

Two-dimensional treatment of the menopause

SUPPLIED: Bottles of 60 tablets.
Each tablet contains:

MILTOWN® (meprobamate, Wallace) **400 mg.**
2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate.
U. S. Patent No. 2,724,720.

Conjugated Estrogens (equine) **0.4 mg.**
Licensed under U. S. Patent No. 2,429,398.

DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods. Should be adjusted to individual requirements.

Samples and literature on request.

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MILTOWN®
A Proven Tranquilizer
+
CONJUGATED ESTROGENS (EQUINE)
A Proven Estrogen

WALLACE LABORATORIES, *New Brunswick, N. J.*
who discovered and introduced Miltown, the original meprobamate.



now "... *care of the man rather than merely his stomach.*"[1]



"Milpath"

Miltown® + *anticholinergic*



controls

gastrointestinal dysfunction

at cerebral *and* peripheral levels

tranquilization without barbiturate loginess

spasmolysis without belladonna-like side effects

for *duodenal ulcer • gastric ulcer • intestinal colic spastic and irritable colon • ileitis • esophageal spasm G. I. symptoms of anxiety states*

prescribe: 1 tablet t.i.d. at mealtime and 2 at bedtime.



"Milpath"

Miltown® + *anticholinergic*



Formula:

Miltown® (meprobamate) 400 mg. (2-methyl-2-*n*-propyl-1, 3-propanediol dicarbamate)
U. S. Patent 2,724,720
tridihexethyl iodide 25 mg. (3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethiodide)

1. *Wolf & Wolff, Human Gastric Function*

Literature, samples, and personally imprinted peptic ulcer diet booklets on request.

WALLACE LABORATORIES New Brunswick, N.J.



why California table wine in the low-sodium diet?

TABLE I[1]

	No. specimens examined	Sodium (mg./100 cc.) Meon
Musts (crushed white grapes)	9	1.63
California Red Table Wines	82	5.56
California White Table Wines	73	5.44
California Dessert Wines	104	7.10

*D*ietary restriction of sodium has become a standard procedure in the control of edema associated with cirrhosis of the liver, congestive heart failure, certain kidney ailments, toxemias of pregnancy, during digitalization and in drug-induced diuresis.

Unfortunately sodium-restricted diets tend to be flat, tasteless, monotonous, leading toward failure of dietary cooperation by the patient.

In such cases California table wine may be employed safely as well as to advantage in making the food more palatable without adding significant amounts of sodium.

In a recent study[1] it was shown that California table wines are remarkably low in sodium content—less than 10 mg. per 100 cc. (3½ ounce glass).

Since recent research [2,3,4] has also shown that wine stimulates a lagging appetite and aids digestion while adding a sparkle to any meal—why not encourage the moderate use of wine by the patient on a restricted dietary, as well as by the sufferer from anorexia, the post-surgical, convalescent or geriatric patient?

May we send you a copy of "Uses of Wine in Medical Practice"? A copy is available to you, at no expense, by writing to: Wine Advisory Board, 717 Market Street, San Francisco 3, California.

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3. Irvin, D. L. and Goetzl, F. R.: Permanente Found. M. Bull. 9:119 (Oct.) 1951.
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(Continued from page 407)

elected to membership on the American Board of Anesthesiology. Locally, he was a member of the staff at St. Vincent's, St. Luke's and Brewster hospitals and the Duval Medical Center. He was a communicant of the Episcopal Church, and a Mason and member of the Scottish Rite Bodies.

A life member of the Duval County Medical Society, Dr. Beckman also was a life member of the Florida Medical Association, in which he held membership for 45 years. Through the years he had, in addition, been affiliated with the American Medical Association. He was a fellow of the International College of Anesthesiology and held membership in other societies of his specialty.

Surviving are the widow, Mrs. Clara Braun Beckman, and a son, John A. Beckman, of Jacksonville; a brother, Dr. John C. Beckman, of Georgetown, S. C.; and two nephews.

James A. Smith

Dr. James A. Smith of Sanford died on Feb. 19, 1957, at the home of his son, Dr. James A. Smith Jr., in New Smyrna Beach after an illness of two months. He was 68 years of age.

Born May 31, 1888, in Fletcher, W. Va., Dr. Smith attended public schools in his native state and received his academic education at Marshall College in Huntington, W. Va., and Valparaiso University in Indiana. He was graduated from the Chicago College of Medicine and Surgery in 1915 and was licensed to practice medicine in West Virginia that same year. He practiced there until 1943, when he came to Florida. He located in Sanford and continued in the general practice of medicine there until he became ill in December 1956. Locally, he was a member of the Masonic Lodge and the First Baptist Church.

Dr. Smith was a past president of the Seminole County Medical Society. He had for 14 years held membership in the Florida Medical Association and was also a member of the American Medical Association.

Survivors include the widow, Mrs. Ethel M. Smith, of Sanford; two sons, Dr. James A. Smith Jr., of New Smyrna Beach, and William P. Smith, of Sanford; two brothers, Perry G. Smith, of Charleston, W. Va., and S. D. Smith, of Kentucky, W. Va., one sister, Miss Florence Smith, of Kentucky, W. Va., and five grandchildren.

when anxiety and tension "erupts" in the G. I. tract...

IN GASTRIC ULCER



PATHIBAMATE*

Meprobamate with PATHILON® Lederle

Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of gastric ulcer — without fear of barbiturate loginess, hangover or habituation . . . *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

*Trademark ® Registered Trademark for Tridihexethyl Iodide Lederle

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

Ralph Sommerkamp Torbett

Dr. Ralph Sommerkamp Torbett of Tampa died at St. Joseph's Hospital in that city on April 28, 1957, following critical injuries sustained in an automobile accident near Crystal River on April 1, 1957. He was 63 years of age.

Born in Columbus, Ga., in 1893, Dr. Torbett was educated in his native state. The University of Georgia awarded him the degree of Bachelor of Arts, and in 1919 the School of Medicine of that institution conferred upon him the degree of Doctor of Medicine. After serving internships at hospitals in Macon, Ga., he continued his postgraduate study in New York, where he served on the staff of the Roosevelt Hospital.

In 1924, Dr. Torbett entered the private practice of medicine in Tampa, where he continued to engage in the practice of his specialty of internal medicine for 33 years. He served on the staff of the Tampa General Hospital and was Chief of Medicine on the staff of St. Joseph's Hospital at the time of his death. He was a member of the Tampa Yacht and Country Club and of the Hyde Park Methodist Church.

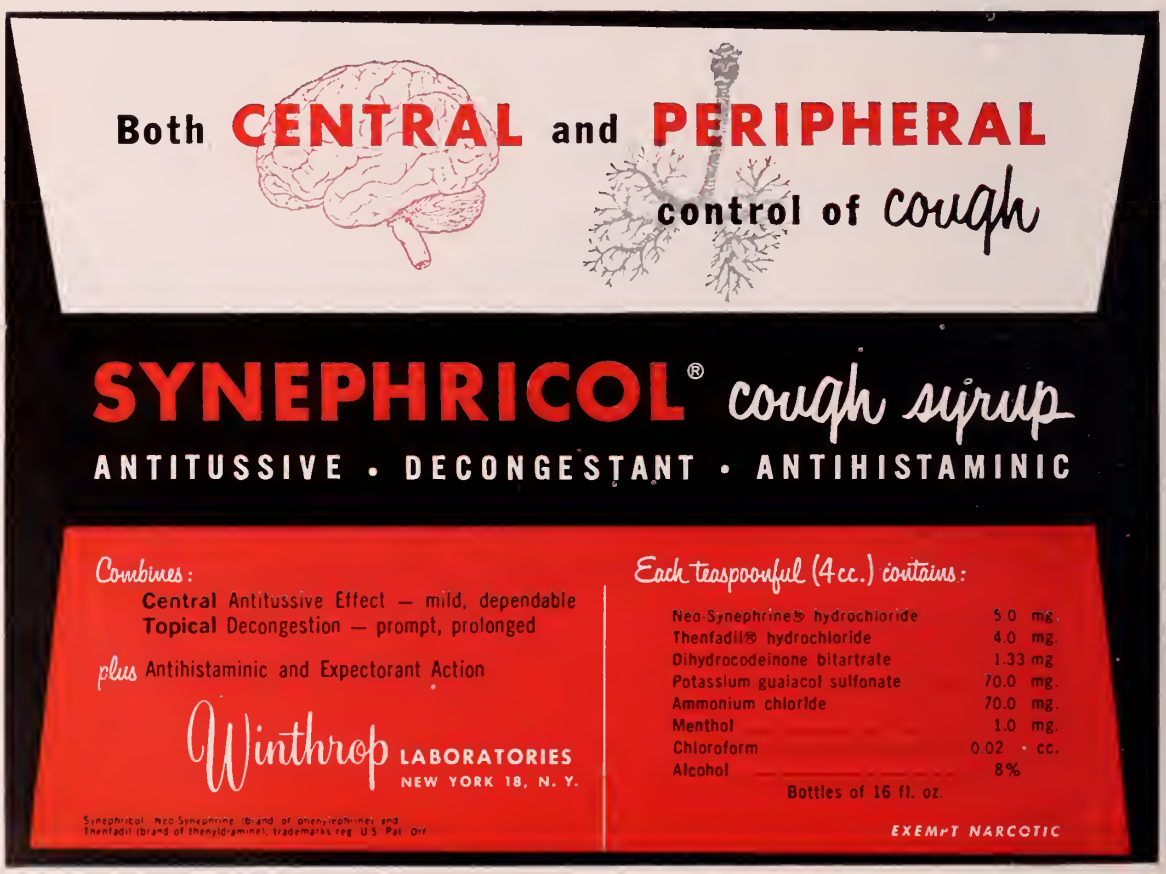
This distinguished internist was a past president of the Hillsborough County Medical Association. He had been affiliated with the Florida Medical Association since 1925 and through the years held membership in the American Medical Association and the Southern Medical Association. He was one of the founders of the Hillsborough County Heart Association, and was serving as its vice president. He was also active in the Florida Heart Association.

Dr. Torbett is survived by his widow, Mrs. Jesse Torbett; one daughter, Mrs. Charles E. Ford Jr.; two granddaughters, Nancy Joan and Charlton Ford, all of Tampa; two brothers, Charlton Torbett and Joseph L. Torbett, both of Columbus, Ga.; and two sisters, Mrs. C. W. Crocker, of Birmingham, Ala.; and Miss Louise Torbett, of Columbus, Ga.

Benjamin Arthur Wilkinson

Dr. Benjamin Arthur Wilkinson of Tallahassee died April 12, 1957, at the Baptist Hos-

(Continued on page 427)



the
paration
you've
asked
for

ANNOUNCING: a NEW antidiarrheal for more certain control of virtually all diarrheas



Addition of neomycin to the
fective DONNAGEL formula assures
n more certain control of most
of the common forms of diarrhea.
Neomycin is an ideal antibiotic
nteric use: it is effectively
acteriostatic against neomycin-
ceptible pathogens; and it is
elatively non-absorbable.

The secret of DONNAGEL WITH NEOMYCIN's clinical dependability lies in the comprehensive approach of its rational formula:

COMPONENT in each 30 cc. (1 fl. oz.)	ACTION	BENEFIT
Neomycin base, 210.0 mg. (as neomycin sulfate, 300 mg.)	antibiotic	Affords effective intestinal bacteriostasis.
Kaolin (6.0 Gm.)	adsorbent, demulcent	Binds toxic and irritating substances. Provides protective coating for irritated intestinal mucosa.
Pectin (142.8 mg.)	protective, demulcent	Supplements action of kaolin as an intestinal detoxifying and demulcent agent.
Dihydroxyaluminum aminoacetate (0.25 Gm.)	antacid, demulcent	Enhances demulcent and detoxifying action of the kaolin-pectin suspension.
Natural belladonna alkaloids: hyoscyamine sulfate (0.1037 mg.) atropine sulfate (0.0194 mg.) hyoscine hydrobromide (0.0065 mg.)	anti-spasmodic	Relieves intestinal hypermotility and hypertonicity.
Phenobarbital (¼ gr.)	sedative	Diminishes nervousness, stress and apprehension.

Robins

Informational literature available upon request.

INDICATIONS: DONNAGEL WITH NEOMYCIN is specifically indicated in diarrheas or dysentery caused by neomycin-susceptible organisms; in diarrheas not yet proven to be of bacterial origin, prior to definitive diagnosis. Also useful in enteritis, even though diarrhea may not be present.

SUPPLIED: Bottles of 6 fl. oz. At all prescription pharmacies.

DOSAGE: Adults: 1 to 2 tablespoonfuls (15 to 30 cc.) every 4 hours. Children over 1 year: 1 to 2 teaspoonfuls every 4 hours. Children under 1 year: ½ to 1 teaspoonful every 4 hours.

ALSO AVAILABLE: DONNAGEL, the original formula, for use when an antibiotic is not indicated.

A. H. ROBINS CO., INC., RICHMOND 20, VA. • *Ethical Pharmaceuticals of Merit since 1878*

Flu Fight

Drug Firms Speed
Vaccine Output, B
Will the U.S. Nee

Asiatic Virus Raises T
Government Buys,
nd Hens Have to H

en Attack, Rapid S

8 STUDENTS ON FLIGHTS TO U. S. HAVE ASIAN FLU

New York, Aug. 15 (AP) Laboratory tests on e foreign exchange student arrived Aug. 8 show they victims of Asiatic flu, the health department repo today. The eight arrived plane from Europe.

Twenty-nine other stud suffering from influenza rived Tuesday from Rot dam on the ship Arosa Sky. One, Nicholas Memmos, Greek exchange student, die yesterday. Six of these stu dents were released today the others are to be re tomorrow. It has not termined whether died from Asiatic

THE INFLU

How Deadly Will i
What Can We Do

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e War on Mutant A

f Florence was in the grip of an epi- nic of colds, coughs and fevers, astrolo- s . . . declared that it was caused by influence of an unusual conjunction of ets. This sickness be known as "infl
—Chronicles of 1200-1470.

'o combat new r nce," a worldwide week in respons n the Far East. Si he World Health a, which collects i n around the globe cimens of the ene s. In more than a uding those of th

Asian Flu: the Outlook

Asian influenza will hit the U.S. this fall before mass immunization can be effective, and the nation faces an epidemic which may strike 15 million to 30 million people. The disease is relatively mild (in no way comparable to the killing "Spanish flu" of 1918-19), and is likely to cause only a small number of deaths among the feeble young and enfeebled old. But it may compel 10% to 20% of the population in affected areas to tak thus

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Pea vac izat flo the ority States

U.S. Fighting

The War On Asiatic Flu

There's cause for concern about Asiatic flu, but scientists and public health officials see no reason for anyone to panic.

First shipments of the vaccine against the new influenza strain have arrived in Chicago, setting off a flood of telephone calls from worried patients to doctors, and from doctors to drug suppliers. This is a nor pattern of mass fear and is understan

The of the

Even though Salk vaccine priorities were necessary, the regulation produced administrative headaches, public complaints and probably a gray, if not a black market. When regulation i invoke it. would h

PUBLIC HEALTH

Influenza

➤ INFLUENZA, one of the m dictable of communicable disease ing "on cat feet" across the na now. It has already struck once in mild epidemic form at an base in Colorado. When and ho it will strike again is a perennial public health authorities.

to counteract
complications from

"ORIENTAL FLU"

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ATCH "ASIATIC" FLU—

e New Virus Threat From Orient

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filmtab®

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STEARATE (Erythromycin Stearate, Abbott)

effective against staph-, strep- and pneumococci

Abbott

Recent Observations

On Self-Regulated Schedules For Infants

Genetically acquired behavioral predispositions enable the normal baby to regulate its feeding intake and periodic hunger sensations, its feeding habits. These physiological regulatory forces may be satisfied by adapting the formula content and feeding period to the individual needs of the infant. It involves a sensible compromise between too rigid a schedule, geared to the clock and too lax a schedule, based on self-demand feedings. Such is the current objective: for either extreme can lead to infant feeding difficulties.

The newborn may become a feeding problem if the prescribed formula is excessive or the feeding schedule rigid. Every time he is awakened abruptly from satisfying slumber to be fed forcefully, the baby gradually loses his enthusiasm for the food and begins to resist the feeding. The young infant may balk at the crude introduction of a new food or feeding procedure without the proper prelude of gradual adaptation of taste, color, consistency and quantity.

The older infant weaned from bottle to cup may reject milk or go on a hunger strike. Devoted to his bottle he resents its sudden deprivation. It takes a certain readiness for weaning to make that change agreeable. Later the infant becomes somewhat independent of his mother and arbitrary with his food. What he enjoyed yesterday, he rejects today. If he distorts the diet for a day and his mother resorts to force, a feeding problem is in the making. Sensible decorum will solve these little difficulties before they become big behavior disturbances in childhood.

The problems of infant feeding are always the same but solutions may differ with each era. The carbohydrate requirement for all infants is as completely fulfilled by KARO® Syrup today as a generation ago. Whatever the type of milk adapted to the individual infant, KARO may be added confidently because it is a balanced mixture of low sugars, easily mixed, well tolerated, palatable, hypoallergenic, resistant to fermentation, easily digestible, readily absorbed, non-laxative. Readily available in all food stores.

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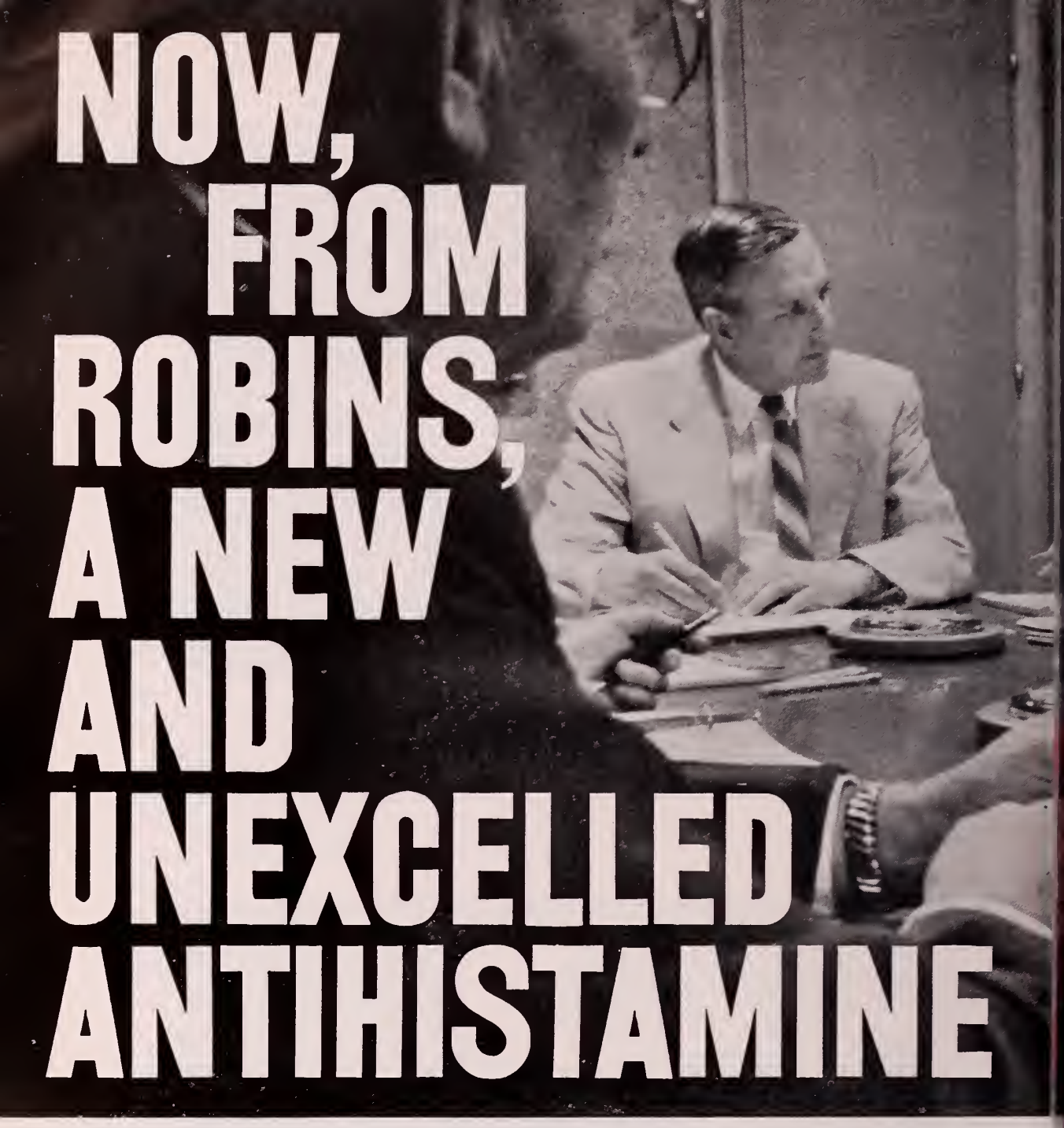
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Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Drowsi
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsi
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5 Dizzy (1)

» unexcelled antihistaminic action

From the preliminary **Dimetane Extentabs** studies of three investigators. Further clinical investigations will be reported as c



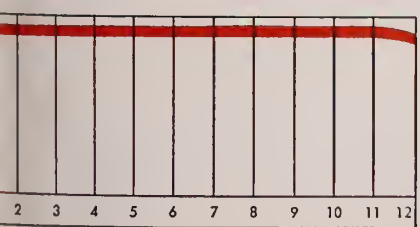
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Children over 6—One tab. or two teaspoonfuls Elixir t.i.d. or q.i.d., or one Extentab q.12h.

Children 3-6—½ tab. or one teaspoonful Elixir t.i.d.

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Same case after treatment with Hydrolamins. Note healing of the inflamed, fissured and excoriated areas and of the whitened anal folds.

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1. Bodkin, L. G., and Ferguson, E. A., Jr.: Am. J. Digest. Dis. 18:59 (Feb.) 1951. 2. Arthur, R. P., and Shelley, W. B.: J. Invest. Derm. 25:341 (Nov.) 1955. 3. McGivney, J.: Texas J. Med. 47.770 (Nov.) 1951.

(Continued from page 418)

pital in Pensacola. Dr. and Mrs. Wilkinson were en route from New Orleans, where he had undergone a medical examination. He was 60 years of age.

Born in Quitman, Ga., on July 29, 1896, Dr. Wilkinson was educated in his native state. He received his medical training at the University of Georgia School of Medicine and was awarded the degree of Doctor of Medicine in 1924. He interned at the Georgia Baptist Hospital in Atlanta.

Dr. Wilkinson practiced medicine in Tallahassee for 32 years. He was a member of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, the Florida Medical Association, the American Medical Association and the American Academy of General Practice. He served as secretary-treasurer of the Leon County Medical Society for nine years. He was on the executive staff of the Tallahassee Memorial Hospital and at one time was college physician for the Florida State College for Women.

Dr. Wilkinson was a deacon of the First Baptist Church. He was a member of the American Legion and the Elks Lodge 937 and was a veteran of World War I.

Surviving are the widow, Mrs. Kathleen Perry Wilkinson, of Tallahassee; one daughter, Mrs. Roderick K. Shaw Jr., one granddaughter, Floride Elizabeth Shaw, and one grandson, Roderick K. Shaw III, all of Tampa; one brother, Dr. James C. Wilkinson, of Athens, Ga.; and one sister, Mrs. A. H. Robinson, of Adel, Ga.

BOOKS RECEIVED

Medical Services for Rural Areas. *The Tennessee Medical Foundation.* By Willman A. Massie. Pp. 68. Price, $1.25. Published for The Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1957.

A group of physicians in Tennessee experienced an unpleasant twinge of conscience when presented with the picture of Pruden Valley. They decided to do something about it and other communities like it. This is the story of their effort, resulting in a program to improve the health service for a group of communities in rural Tennessee, and a fascinating story it is. Realizing that organized medicine in the state had a moral obligation to extend good medical care to all the people of Tennessee, the Board of Trustees of the Tennessee State Medical Association delegated to the Tennessee Medical Foundation, an organization the Association had founded to advance medical knowledge and service, the task of establishing and financing adequate medical facilities in Pruden Valley and other areas in the eastern Tennessee mountains. Grants from The Commonwealth Fund furthered the project with these results:

"The Foundation's effort has served to curb costly mistakes, to plan wisely the material facilities to fit long-range needs, to develop the type of service best suited to each community's health requirements and economic

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esources, to teach the people and the medical profession o work together with dedication toward alleviation of uffering and long-range improvement in health of all the eople in each community. This, then, is the direction f a program 'based on the acceptance of the fundamenal philosophy that organized medicine can and should ssume an active role in the medical affairs of local comnunities and shall stand in a position to materially assist nd insure the provision of good medical care to the eople of the State of Tennessee.' "

Ciba Foundation Symposium on Paper Electrophoresis. Editors for the Ciba Foundation, G. E. W. Volstenholme, O.B.E., M.A., M.B., B.Ch., and Elaine C. P. Millar, A.H-W.C., A.R.I.C. Pp. 224. Illus. 74. Price, $6.75. Boston, Little, Brown and Company, 1956.

This is the first book to appear in which the world's eading experts in the field of paper electrophoresis toether present their work. It is the end result of a ymposium, held at the Ciba Foundation in London, lesigned to lead to the employment of methods allowng a much better basis of comparison between different indings in laboratories.

Paper electrophoretic technic has become an increasngly important diagnostic tool. Workers in many counries have proceeded along independent lines during the eriod of development. Now, in this convenient volume, hose who have made important, original contributions exchange their views with an eye to standardizing methds, results and apparatus. Through formal papers and nformal discussions the applications of paper electrohoresis to protein chemistry are explored. Quantitative nethods and the criteria for those methods are discussed.

Outstanding among the many topics covered are: eneral methods of paper electrophoresis and their use n medical and biochemical problems; evaluation of the lbumin-globulin ratio of blood plasma or serum by aper electrophoresis; analysis of human hemoglobins by paper electrophoresis; physicochemical aspects and their relationship to the design of apparatus; the future of the technic in its application to clinical research and routine analysis.

A Visit to the Hospital. By Francine Chase. Pp. 68. Price, $1.50. New York, Grosset & Dunlap Inc., 1957.

The purpose of this well illustrated book is to allay the fears and anxieties of children who are about to undergo surgical experience in a hospital. It incorporates all the psychologic principles for the emotional preparation of children for surgery established by educators, psychologists and surgeons everywhere. Written under the supervision of Dr. Lester L. Coleman, an ear, nose and throat surgeon who is particularly identified with psychosomatic concepts in medicine, the book carries an introduction by Dr. Flanders Dunbar, Editor-in-Chief, Emeritus, American Psychosomatic Society. A Visit to the Hospital is primarily directed towards the removal of the tonsils since two to three million such operations occur yearly in America. Because a tonsil operation can be planned for, this book can help to convert an emotionally traumatic experience into a productive growth experience of childhood. Dr. Coleman believes that the teachings of this book can apply likewise for eye surgery or any other elective or even emergency operation.

Human Blood Groups and Inheritance. By Sylvia D. Lawler, M.D., and L. J. Lawler, B.Sc. Pp. 103. Price, $1.50. Cambridge, Mass., Harvard University Press, 1957.

This little book offers a readable, accurate and up-to-date account of the human blood groups, for both the

(Continued on page 432)

when anxiety and tension "erupts" in the G. I. tract...

IN ILEITIS



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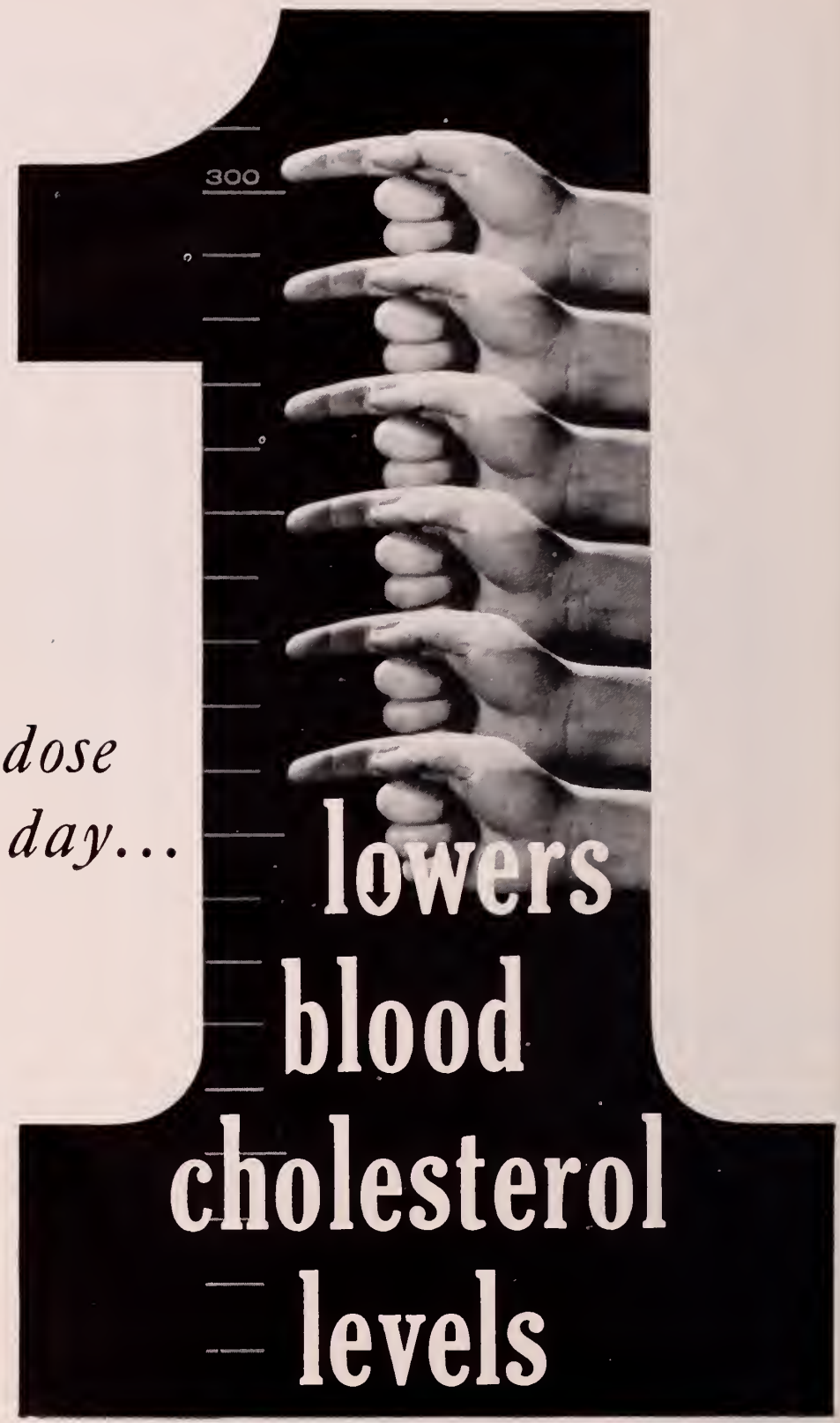
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(Continued from page 429)

biologist and the lay reader. As stated in the Foreword, blood groups are of importance in medicine, in anthropology and occasionally in the law, and all these aspects are dealt with in this book. "But to the reader with a general interest in biology the most fascinating aspect must surely be their inheritance. In no species could clearer or simpler examples be found of the basic mechanism of heredity discovered by Mendel in the garden pea over 80 years ago.

"The exact manner of inheritance of only eleven normal human characters is yet known with certainty. Since nine of these characters are blood groups, it is important that all students of biology should have some knowledge of this subject. They could have no better guides than Mr. and Dr. Lawler, who have here provided a complete and authoritative account in a commendable concise form."

Rypins' Medical Licensure Examinations: *Topical Summaries and Questions.* By Walter L. Bierring, M.D., M.A.C.P., M.R.C.P., Edin. (Hon.), with the Collaboration of a Review Panel. Ed. 8. Pp. 964. Price, $10.00. Philadelphia, J. B. Lippincott Company, 1957.

A panel of outstanding teachers and clinicians has collaborated with the present editor to ensure the continued usefulness of this worth while publication, originally written and revised by the late Harold Rypins, M.D. The original plan has been retained in this eighth edition —separate summaries of each subject and actual questions based on the essential facts contained in each summary. The Table of Contents is divided into two parts: Part One, Basic Medical Sciences, including Anatomy, Physiology, Biochemistry, Microbiology, Pathology and Pharmacology; Part Two, the Clinical Sciences, including Surgery, Medicine, Obstetrics and Gynecology, Preventive Medicine and Public Health, and Psychiatry.

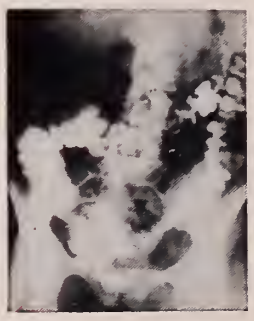
It is hoped that this publication will continue to interest both the examiner and the examinee and enlist the cooperation of the medical educator in the broad field of licensure and other types of qualifying examinations. It also provides the undergraduate student with a compact and orderly presentation of the several fields of medicine which will permit of a dependable review of the material covered in the medical course.

Health Services for American Indians. U. S. Department of Health, Education, and Welfare, Public Health Service, Office of Surgeon General, Division of Public Health Methods. Pp. 344. Price, $1.75. Public Health Service Publication No. 531. Washington, D. C., Superintendent of Documents, U. S. Government Printing Office, 1957.

The study here reported was divided into four major areas: 1. Indian health status and needs; 2. Medical care and hospital services; 3. Public health and preventive services, and 4. Economic and social resources available for health purposes. In submitting this report to the Committee on Appropriations of the House of Representatives, Secretary Folsom of the Department of Health, Education, and Welfare, wrote: "The report which I am sending you, and the appended study of health problems among the Alaska natives which was made two years ago, clearly indicate the intricate interplay of health and social, economic, educational and other nonmedical problems. While health measures alone cannot solve the whole problem, the survey findings and data do provide an essential factual base for the planning of positive steps which can be taken to improve the health level of Indians. Many concrete recommendations are made with the dual purpose of reducing preventable illness and death and at the same time advancing the orderly integration of Indian and non-Indian health programs and services."

when anxiety and tension "erupts" in the G. I. tract...

in spastic and irritable colon



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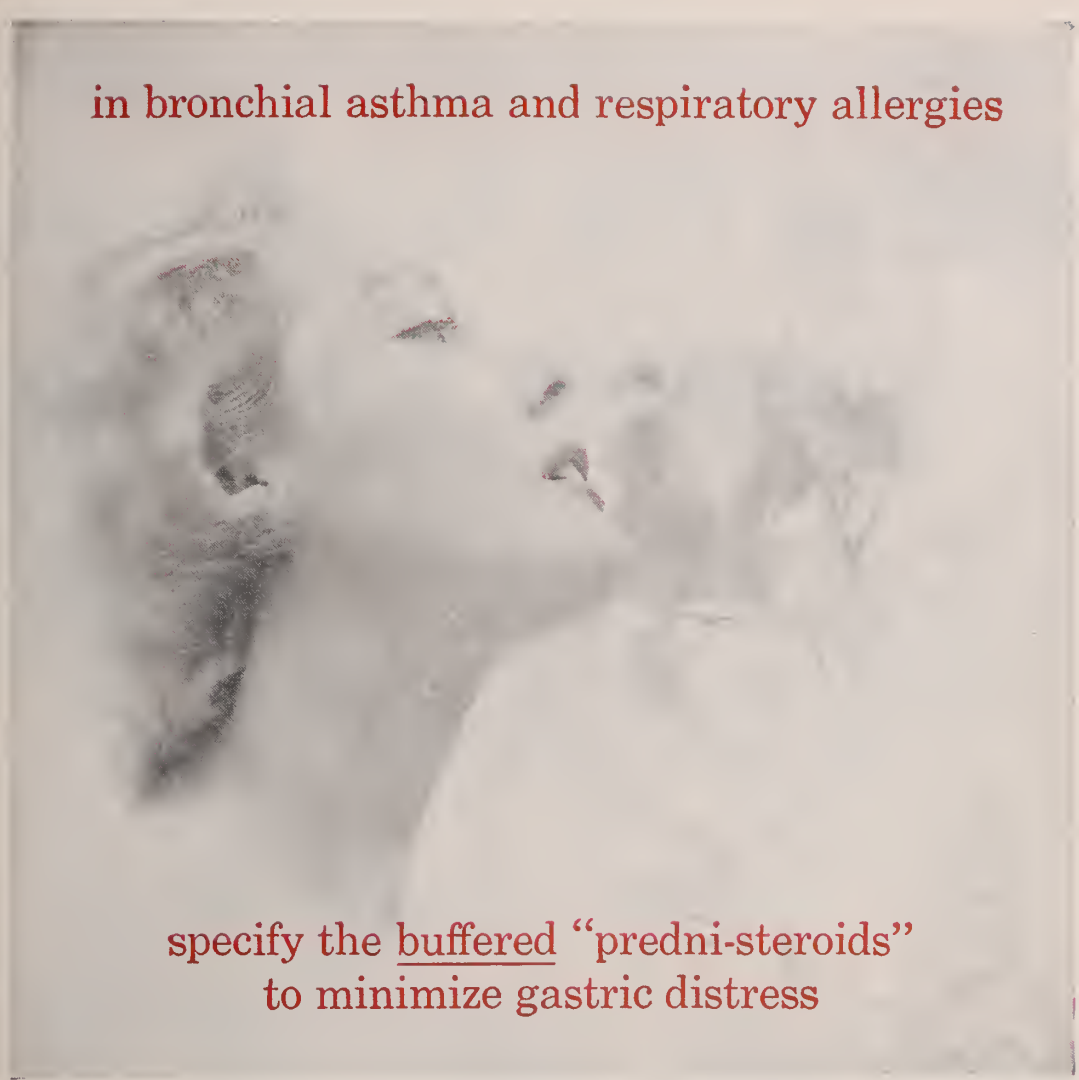
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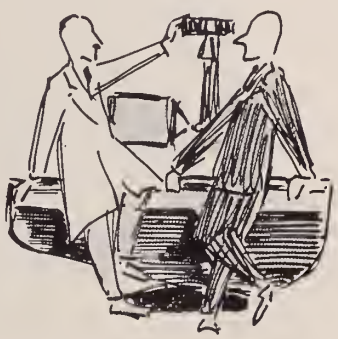
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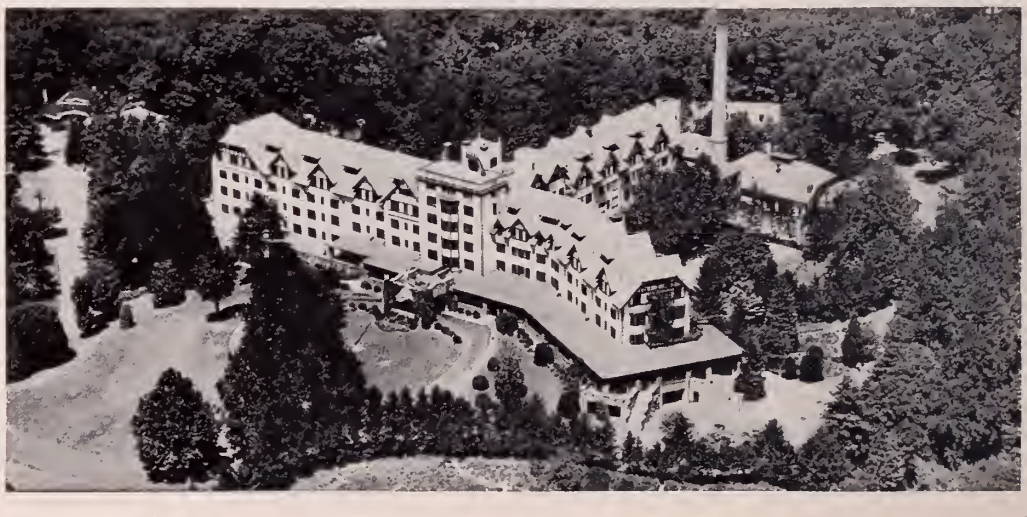
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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Glenn O. Summerlin, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	64
***Bradford, Gilchrist, Union**				
Bay	John J. Benton, Panama City	Lloyd B. Harrison Jr., Panama City	1st Tues.	29
Brevard	Myron L. Habegger, Rockledge	Louis C. Jensen Jr., Rockledge	2nd Tues.	52
Broward	Walter J. Glenn Jr., Fort Lauderdale	Garland M. Johnson, Fort Lauderdale	4th Tues.	170
Collier	James A. Craig, Naples	Ethel H. Trygstad, Naples	3rd Wed.	9
Columbia	Thomas H. Bates, Lake City	Laurie J. Arnold Jr., Lake City	1st Mon.	11
***Baker**				
Dade	Walter W. Sackett Jr., Miami	Vincent P. Corso, Miami	1st Tues.	821
DeSoto-Hardee-Highlands-Glades	Godfrey L. Beaumont, Sebring	Theodore W. Weeks Jr., Sebring	1st Tues.	28
Duval	Leo M. Wachtel, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	332
***Clay**				
Escambia	Paul F. Baranco, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	111
Franklin-Gulf	Photis J. Nichols, Apalachicola	William F. Wager, Port St. Joe	Last Wed.	7
Hillsborough	Madison R. Pope, Plant City	James A. Winslow Jr., Tampa	1st Tues.	225
Indian River	Walter W. McCorkle, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	10
Jackson-Calhoun	William W. Richardson, Graceville	Francis M. Watson, Marianna	Quarterly	15
Lake	Fred A. Vincenti, Mount Dora	J. Basil Hall, Tavares	1st Wed.	31
***Sumter**				
Lee-Charlotte-Hendry	James L. Bradley, Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	George S. Palmer, Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	76
Madison	Julian M. DuRant, Madison	A. Franklin Harrison, Madison		8
Manatee	Joseph A. Gibson, Bradenton	Warren G. Darty, Palmetto	2nd Tues.	31
Marion	John D. Lindner, Ocala	Robert L. Gibson, Ocala	3rd Tues.	36
***Levy**				
Monroe	Robert W. Reid, Key West	Joseph J. Scarlet, Key West	1st Thurs.	13
Nassau	Benj. F. Dickens, Fernandina Beach	David D. Bennett Jr., Callahan	1st Thurs.	9
Orange	Frank J. Pyle, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	219
***Osceola**				
Palm Beach	Edward W. Wood, Lake Worth	Robert Y. Wheelihan, Riviera Beach	4th Mon.	158
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs	19
Pinellas	Percy H. Guinand, Clearwater	Whitman C. McConnell, St. Petersburg	1st Mon.	260
Polk	John P. Tomlinson Jr., Lake Wales	Charles Larsen Jr., Lakeland	2nd Wed.	115
Putnam	Alfred P. Peretti, Palatka	Norman B. Edgerton, Palatka	2nd Tues.	11
St. Johns	Milton Segal, St. Augustine	William J. Gibson, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	John M. Gunsolus, Stuart	Adrian M. Sample, Fort Pierce	3rd Thurs	28
Sarasota	Samuel E. Kaplan, Venice	James E. Kicklighter, Sarasota	2nd Tues.	69
Seminole	Gordon D. Stanley, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee-Hamilton-Lafayette	Hiram B. Curry, Jasper	William P. Blackmon, Jasper	1st. Sat.	11
Taylor	Charles R. Wiley, Perry	Ralph J. Greene, Perry	Last Fri.	6
***Dixie**				
Volusia	Arthur Schwartz, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	90
***Flagler**				
Walton-Okaloosa-Santa Rosa	Ralph B. Spires, DeFuniak Springs	Howard A. Parker, Valparaiso	3rd Tues.	28
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay		4
			Total	3,184

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Vol. XLIV NOVEMBER, 1957 No. 5

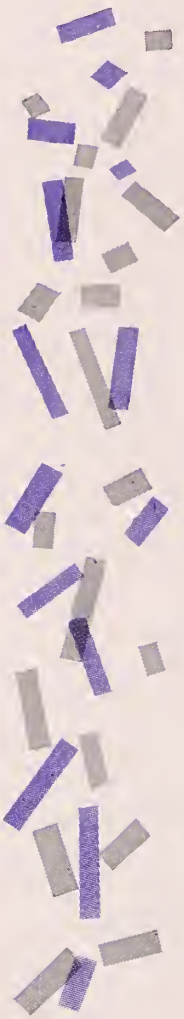


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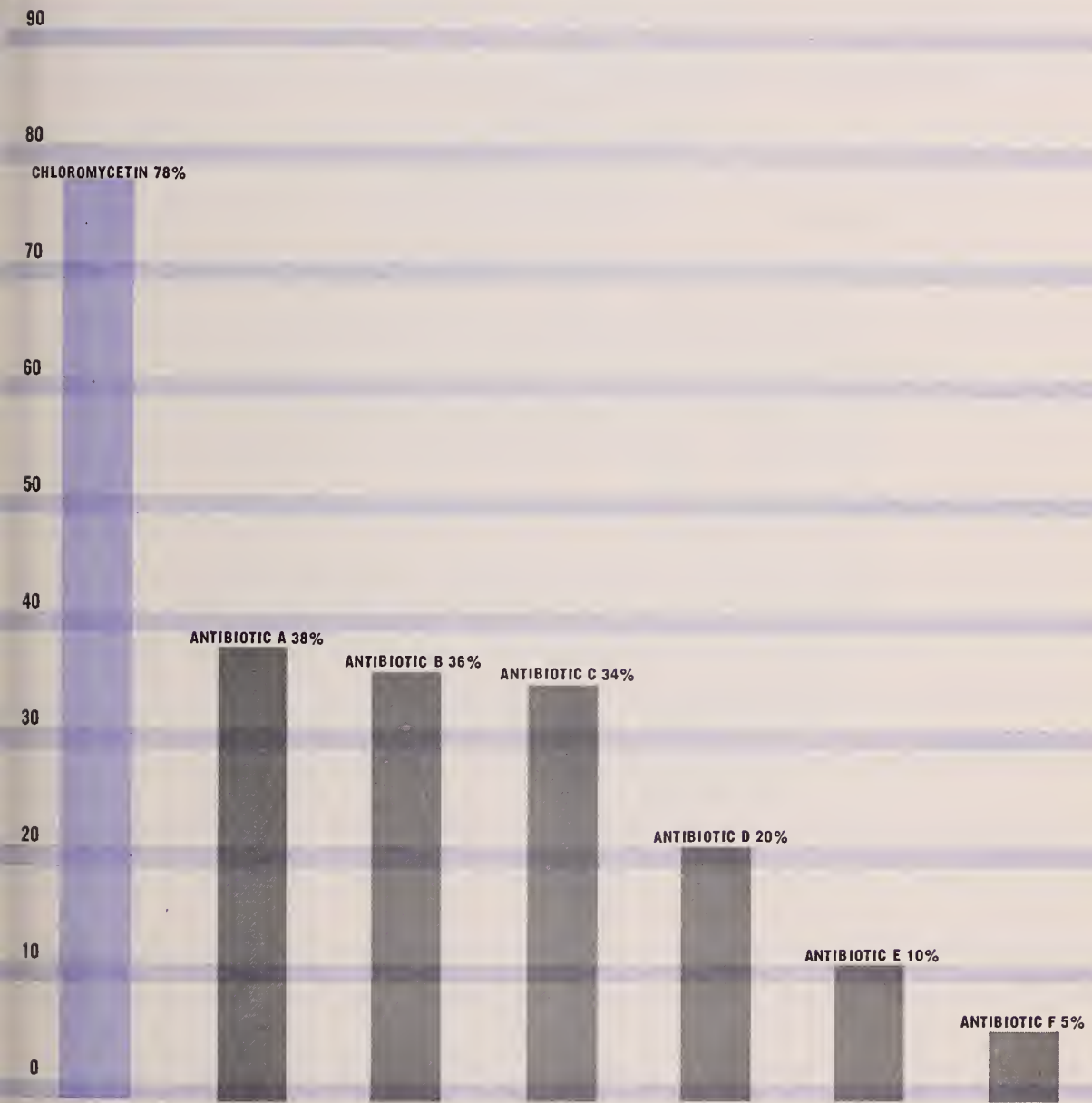
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COMPARATIVE SENSITIVITY OF MIXED PROTEUS SPECIES TO CHLOROMYCETIN AND SIX OTHER WIDELY USED ANTIBIOTIC AGENTS*



*This graph is adapted from Waisbren and Strelitzer.[15] It represents *in vitro* data obtained with clinical material isolated between the years 1951 and 1956. Inhibitory concentrations, ranging from 3 to 25 mcg. per ml., were selected on the basis of usual clinical sensitivity.

The Journal of the Florida Medical Association

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VOLUME XLIV, No. 5 • *November, 1957*

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Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924



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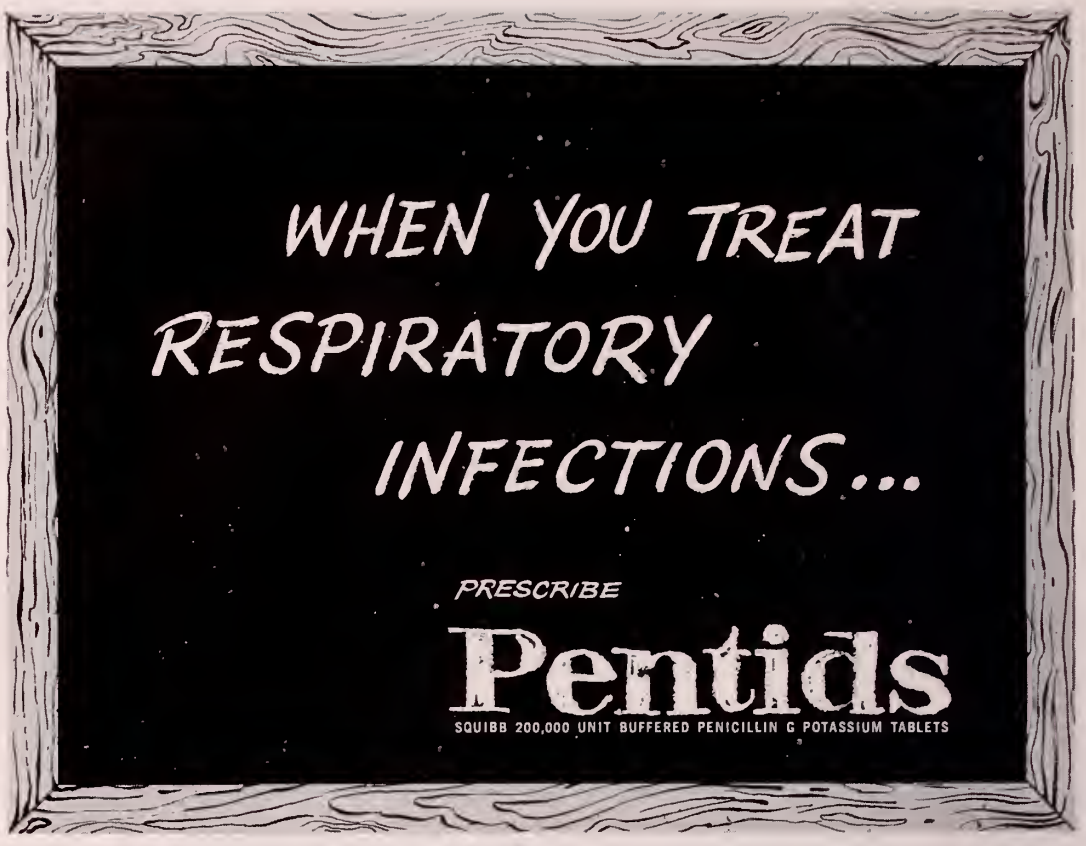
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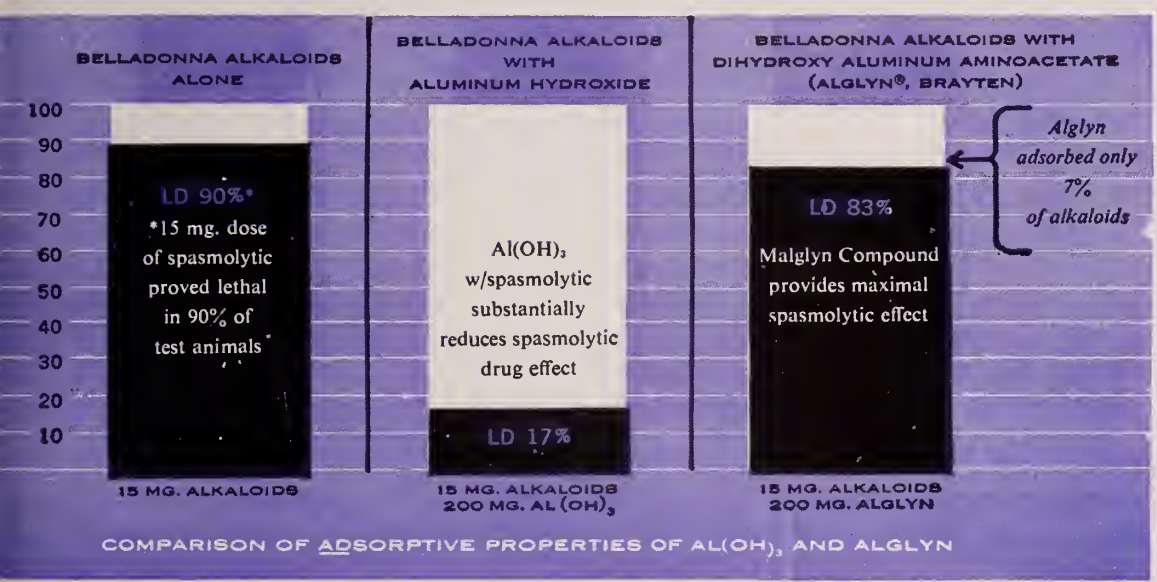
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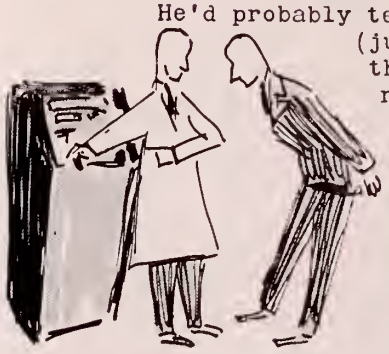
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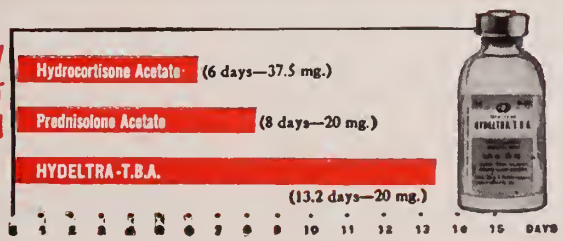
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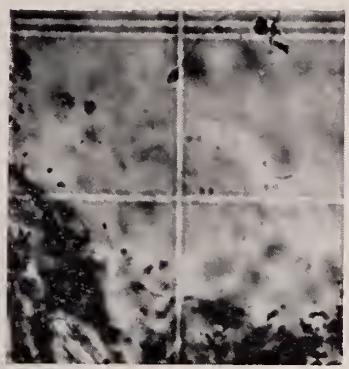
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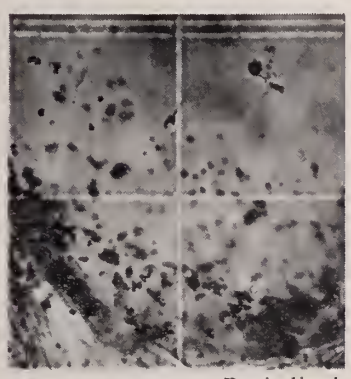
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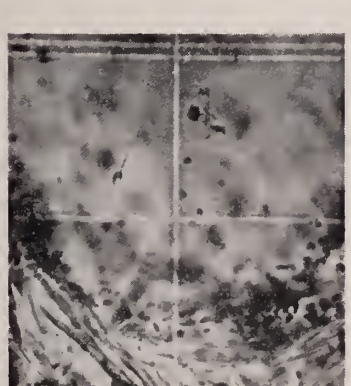
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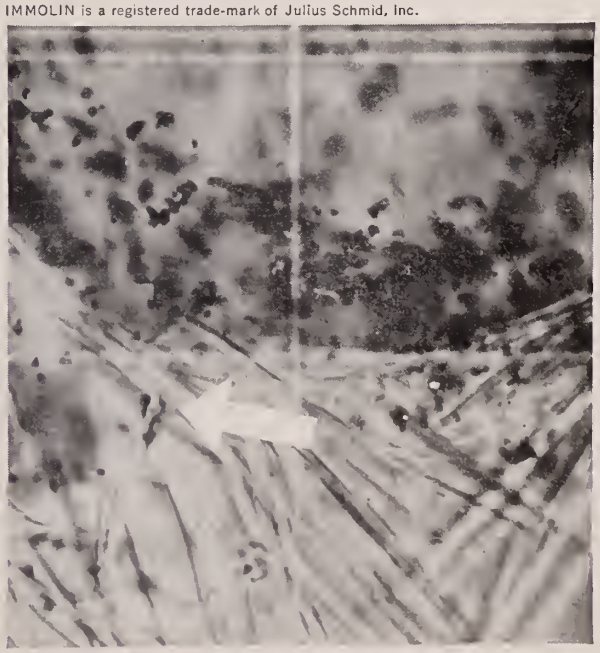
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1. Hodges, F. T.: GP, *14*:86, Nov., 1956.

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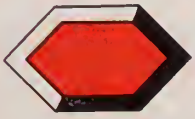
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References: 1. Communication to Abbott Laboratories, 1956. 2. Moyer, J. H. et al: Deserpidine for the Treatment of Hypertension. Southern Medical J., 50:499, April, 1957.

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1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954



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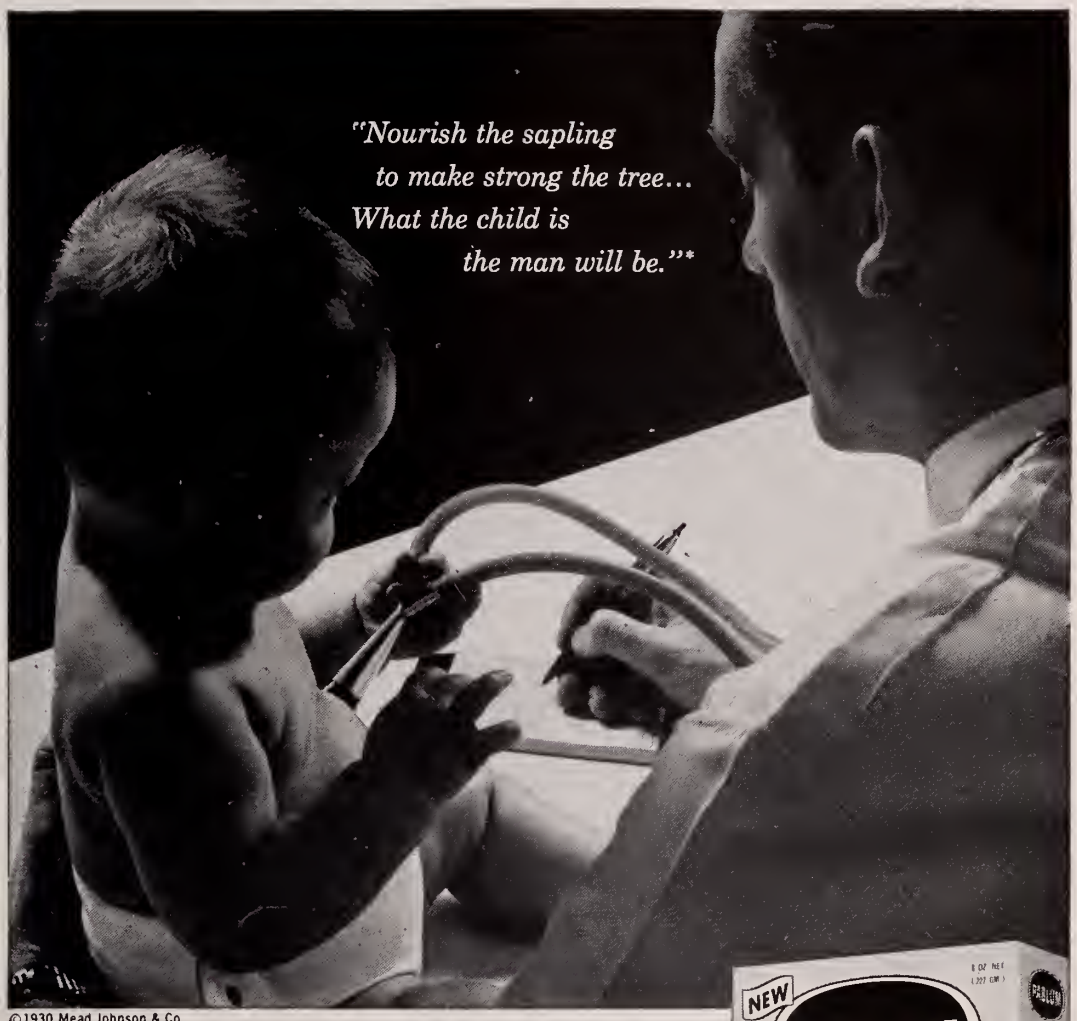
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The Journal of The Florida Medical Association
PUBLISHED MONTHLY

Volume XLIV | Jacksonville, Florida, November, 1957 | No. 5

Complications of Acquired Diseases Of the Aorta

SAMUEL M. DAY, M.D.
AND
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JACKSONVILLE

Many years ago, the great French surgeon, René Leriche,[1] wrote that the ideal treatment of occlusive arterial disease would be to resect the obliterated zone and bridge the vascular defect by graft. Various surgeons attempted ligation,[2] wiring[3] and other methods[4] of dealing with arterial aneurysms without consistent success. Since no therapy warranting optimism existed, little attention was paid to these conditions by the average doctor. Carrel[5] pointed the way for a brighter future with his exceptional experiments in vascular surgery in 1907, but surgeons were long in following his lead.

A new era of surgery was opened by Gross[6] and Crafoord and Nylin[7] in 1945, when they independently and successfully resected a segment of the thoracic aorta for coarctation and restored continuity by end to end suture. The successful resection of diseased segments of arteries by Oudot[8] in 1951 for aortic occlusion, and by Dubost, Allary and Oeconomos[9] and Schafer and Hardin[10] in 1952 for aneurysms, offered untold opportunities in new fields. Mortality and morbidity rates have been reduced to reasonable limits. Excellent men, De Bakey, Cooley, Hufnagel, Shumacker, Creech, Bahnson, Julian, Edwards and others were quick to popularize these procedures. New evaluations in peripheral vascular disease have resulted.

Formerly, the arterial diseases were treated through their myoneural components. Sympathetic blocks and ganglionectomies, and vasodilator drugs and devices were in vogue as the best available therapy. Beyond those, most surgeons dared not go. More tangible methods of treatment have changed our thinking so that emphasis has shifted from the small to the large arteries since the latter are more receptive to successful grafting. Intelligent use of aortography, which was introduced by Dos Santos[11] in 1931, has led to accurate localization of occlusions in major vessels which were formerly thought to be in peripheral arterioles and capillaries. Drugs and surgery of the sympathetic nerves still may have a place in the therapy of vascular diseases, but they no longer play the dominant role. Arteriosclerosis and its complications now share the center of attention.

The addition of "hope" to our armamentarium has alerted us to the complications of these vascular diseases, which too recently were thought to be inevitable sequelae. More of us, however, need to be conscious of the seriousness of the diseases and their complications so that they can be recognized and treated early. Cases in which Buerger's disease, peripheral "neuritis" or "polyneuritis," or "generalized arteriosclerosis" previously was diagnosed or other "inclusive" diagnoses were made, should be re-evaluated. If a specific point of occlusion exists, it should be correctly localized and treated definitively before serious complications develop. Many patients with suspected back, abdominal or urologic problems should be given the benefit of further study.

Arteriosclerotic aneurysms most frequently occur in the terminal portion of the aorta below the origin of the renal arteries.[12] This site is a fortunate feature from a surgical point of view.

Our experience is limited in this new field, but already we have seen some of the tragedies that result from delay. We hope that bringing these cases to the attention of others may enable them to avoid these pitfalls.

The first case, previously reported by us,[13] illustrates the fallacy of thinking that surgery should not be advised because the patient was able to live with his disease. He did not live

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Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 7, 1957.

long. He might have lived longer had foresight had the wisdom of hindsight.

Report of Cases

Case 1. — A 55 year old white man first complained of easy fatigability and claudication in both legs in 1942, at the age of 41 years. Pain in the hip followed. All symptoms gradually progressed in severity. The diagnosis of Buerger's disease was made by physicians in more than one reputable clinic. Nonsurgical measures were prescribed without benefit. Absence of femoral and pedal pulses was noted years ago. Hypertension had been present for an unknown period. He survived a coronary thrombosis and a cerebral vascular accident during 1953 without residual physical defects, except cardiac enlargement. Pallor increased, and swelling of the legs occurred during the six months prior to his final illness.

A huge toxic goiter was treated with radioactive iodine by Dr. Samuel W. Root in July 1955, with temporary improvement. The residual thyroid gland enlarged rapidly in 1956, and a total thyroidectomy was performed by one of us (S.M.D.) on July 2. Adenomatous changes were diffuse throughout the entire gland, but no evidence of cancer was found. The patient withstood the procedure surprisingly well. Thyroid extract, 1 grain daily, was prescribed, with steady improvement in his general condition until he was considering returning to limited work for the first time in years. He denied impotence. The hypertension was reduced from 200 systolic and 90 diastolic to 150 systolic and 80 diastolic. He had been a heavy smoker until May 1956, when he stopped smoking. The leg symptoms did not improve, but they did not seem to progress. Since he could walk two or three blocks before pain stopped him, it was agreed that he was able to live with his symptoms and should be left alone in so far as the Leriche syndrome was concerned. Subsequent events indicated that our reasoning was in error. He continued to take digitalis under Dr. Root's direction.

The patient was seized with a sudden severe epigastric pain after eating a "cold pork chop" on the night of August 30, 1956. The pain was intermittent during the initial 24 hours, but was constant thereafter. He was admitted to St. Luke's Hospital for Dr. Root approximately 12 hours after the onset, at which time he was in moderately severe shock. The impression was that he was suffering from coronary thrombosis, but it soon developed that this was in error. Attention was turned to the abdomen, which was not tender on admission, but moderate tenderness and distention gradually developed. Diagnoses of acute pancreatitis, dissecting aortic aneurysm, and mesenteric thrombosis were entertained when we saw the patient approximately 26 hours after admission. The serum amylase rose to 500 mg. per hundred cubic centimeters, the leukocyte count to 27,500, and the hemoglobin estimation to 17.2 Gm. Bowel sounds disappeared. Abdominal roentgenograms suggested paralytic ileus. Flank paracentesis revealed dark bloody fluid with a foul odor in insufficient amount for amylase determination. The Levin tube drained blood-tinged fluid. Urinary output was negligible.

The patient was not thought to be a fit candidate for surgery. Oxygen and norepinephrine were continued, and a blood transfusion was started. His condition steadily deteriorated, and he died a few hours later, approximately 34 hours after admission.

At autopsy, the thymus was enlarged. The heart showed diffuse moderate hypertrophy, most prominent in the left ventricle.

The abdomen was moderately distended. The abdominal cavity contained 100 cc. of brown hemorrhagic fluid. The stomach and small intestine contained thin hemorrhagic fluid. There was hemorrhagic infarction of the entire jejunum and ileum, with inflammatory changes in the serosa of the right colon.

The aorta showed severe irregular diffuse arteriosclerosis. There were three shallow pouchlike aneurysmal protrusions of the thoracic aorta measuring up to 3.5 cm. in greatest diameter and 1.3 cm. in depth. That of the aortic arch was fusiform, of the descending aorta, saccular, and of the lower portion of the thoracic aorta, fusiform. The walls were thin and fibrous.

The distal abdominal aorta was dilated, measuring 6 cm. in length and 3 cm. in greatest diameter. The lumen of this portion of the aorta was completely replaced by dense, yellowish fibrous tissue. A fresh thrombus occupied the aortic lumen superior to this fibrous area propagating upward within the lumen to overlay and obstruct the superior mesenteric and the left renal arteries (fig. 1). This fresh thrombus obviously caused the infarction of the small intestine. Both iliac arteries were occluded proximally by the dense fibrous process of the lower segment of the aorta secondary to slow thrombosis over many years. Small lumens were present more distally in the external iliac arteries.

This case represents a typical pathologic picture of the Leriche syndrome,[14] or gradual occlusive disease of the aortic bifurcation due to arteriosclerosis. The condition usually originates in adult males in the fourth and fifth decades of life. It is characterized by symptoms of (1) easy fatigability of the legs, (2) pain in the lower part of the back and in the hips, (3) intermittent claudication on walking, and (4) inability to maintain an erection, and later there is total impotence in approximately 30 per cent of the cases.[15] Physical signs include (1) minimal color and trophic changes in both lower extremities, (2) global atrophy of both lower extremities, (3) absence of pulsations in the large and small arteries of the lower extremities, (4) the presence of a midabdominal bruit, and (5) hypertension.



Fig. 1. Case 1. — Descending and abdominal aorta (opened) demonstrating two of the aneurysms of the thoracic aorta; the dilated lower abdominal aorta contains fresh thrombus above the fibrotic occluded bifurcation. The probe lies in the left renal artery.

There was present in this case a complication of the disease about which we have been warned since Leriche's original description, namely, that of ascending thrombosis of the aorta above the older occluded area. The renal arteries are occluded more frequently than the superior mesenteric arteries, although in this case the kidney did not reveal the severe infarction seen in the intestine. It is possible that the fresh propagating thrombus occluded the left renal artery later than the superior mesenteric artery. It is noteworthy that the right colon was not infarcted, particularly since the inferior mesenteric artery was long since occluded by the old occlusion process.

This case is unusual in that it represents the two major types of aortic disease, aneurysmal and occlusive, and death ensued as a result of a complication of the latter. Not only were the two types of disease present, but the two types of aneurysm, saccular and fusiform, were demonstrated, and the thoracic aorta contained two of the latter. Fortunately, such extensive disease is not seen too often in a single patient. In 1948, Leriche and Morel[14] stated: "Aortic thrombosis, although apparently very well-borne for years (5 and even 10) always ends in gangrene." Although mesenteric thrombosis was not specifically mentioned by them, this case illustrates the accuracy of their prediction.

The second case illustrates one of the dangers inherent in aneurysms, particularly if their treatment is delayed, as in this instance by refusal of the patient to submit to operation. De Bakey, Cooley and Creech[16] stated that the average survival time of patients with aneurysms is from one to two years, with rupture being the most common cause of death. The studies of Estes,[17] Kampmeier[18] and Nixon[19] were considered in making this prediction. Certainly, a look at the sac of a few of these aneurysms will make one respect their tendency to burst.

Case 2. — A 64 year old white man was first seen by one of us (S.M.D.) in January 1954 because of a severe abdominal pain associated with partial intestinal obstruction, probably due to further expansion of an aneurysm. There was a history of gradual loss in weight, chronic cough, irregular heart beat, dyspnea and recurrent constipation. Physical examination revealed pronounced clubbing of the fingers, bilateral basilar rales, hypertension, and a large pulsating mass occupying the pelvis and lower part of the abdomen. The symptoms subsided with conservative therapy in St. Vincent's Hospital. An abdominal aortogram confirmed the diagnosis of abdominal aortic aneurysm. The usual pulses were palpable in the lower extremities. Other studies confirmed the diagnosis of severe pulmonary emphysema and cardiac hypertrophy with pulsus alternans. In spite of his poor condition the patient was advised to be treated for the cardiac and pulmonary disease and to consider surgical treatment of the aneurysm. He refused all recommendations, but he did report for periodic examinations because of insurance requirements.



Fig. 2. Case 2. — Opened aneurysmal sac after removal.

He was able to retire to his brother's farm and maintain a small garden, enough work to lose his insurance payments after a year. He had several less severe episodes of abdominal pain, which were probably due to further sudden expansion of the aneurysm. These became more frequent in the fall of 1956. When last seen in the office on October 9, he was urged to consider surgical treatment of his huge aneurysm. In an attempt to prepare him further, we succeeded in getting him to consult an internist, Dr. David R. Moomaw, who prescribed potassium iodide and succeeded in stopping his smoking for three weeks. It is noteworthy that his vital capacity increased from 1 liter to 2.5 liters on this regimen.

On the morning of November 10, the patient experienced a severe agonizing pain in the suprapubic area while attempting to lift a television set. He became weak, had a desire to defecate, and lost consciousness while sitting on the toilet. He was admitted to St. Luke's Hospital by ambulance in moderately severe shock. Blood was ordered immediately by telephone because of our familiarity with the case and its impending catastrophe. During a five hour period of observation he failed to respond adequately to transfusion therapy. Furthermore, an enlarging tender mass in the right flank indicated the site of retroperitoneal hemorrhage. He continued to complain of severe pain in the suprapubic region and in the right leg. The urine output measured 25 cc.

After careful consideration of the immediate problem, surgery was advised as the only hope of survival. The family and patient were informed of the problem and of the high expectant mortality. They consented in view of the hopeless outlook otherwise.

Exploration was carried out through a long midline incision. The aneurysm was firmly wedged into the pelvis and lower part of the abdomen, and was of tremendous size with rupture of the right posterior wall and severe retroperitoneal hemorrhage. The aneurysm originated just below the renal arteries and extended in a baglike manner into the pelvis, terminating abruptly at the bifurcation. There were secondary dilatations of both common iliac arteries. The entire aneurysm was removed (fig. 2) except for a small section of the right posterior lateral wall which was densely adherent to the vena cava (fig. 3) and was not disturbed. The aneurysm measured 30 cm. in its greatest circumference and contained large amounts of old and fresh clotted blood (fig. 4).

Since only two thoracic aortic homografts and no plastic bifurcation prostheses were available, it was necessary that we construct a bifurcation from the two homografts. This was satisfactorily inserted, and linear flow was established after two hours and forty minutes of occlusion. During this time the iliac clamps were released at intervals to back flush the vessels. The vena cava was

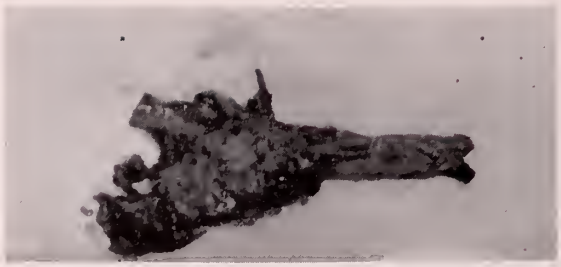


Fig. 3. Case 2. — Segment of aneurysm left attached to interior vena cava.

slightly injured at two points near its bifurcation. It was repaired with arterial silk. A segment of ileum was so densely adherent to the wall of the aneurysm that it was necessary to resect that segment with the sac and perform an end to end ileoileostomy.

The patient did surprisingly well during surgery although the urinary output was nil. He was awake and talking for approximately four hours after surgery; then he slowly lost consciousness. Neo-Synephrine and blood were administered with little rise in pressure. We did not think reoperation indicated or justified. The patient remained anuric and died 11 hours following the completion of surgery.

The autopsy revealed a moderate amount of old and fresh blood in the retroperitoneal space. There was a small tear in the wall of the inferior vena cava adjacent to the area repaired at operation, which could have been caused by the postmortem dissection. The graft was patent and did not leak when water was inserted under pressure of 30 pounds (fig. 5). There was severe parenchymatous degeneration of the kidneys, and arterial and arteriolar nephrosclerosis. An old anterior myocardial infarct, myocardial hypertrophy, and bilateral severe pulmonary emphysema also were present.

There was generalized arteriosclerosis which, interestingly enough, had given rise to two additional complications. One of these was a saccular aneurysm of the proximal aortic arch with a dissecting aneurysm extending into the innominate artery (fig. 6). The other complication was an old thrombosis with complete occlusion of the left subclavian artery at its origin from the aortic arch (fig. 6). This explained the absent pulse and blood pressure in the left arm.

Apparently, the thrombosis of the left subclavian artery at the aorta in this case represents an example of an incomplete "Martorell's syndrome," which was redescribed by Martorell and Fabre[20] in 1944. Successful treatment of such a case by curettement and suction was reported by

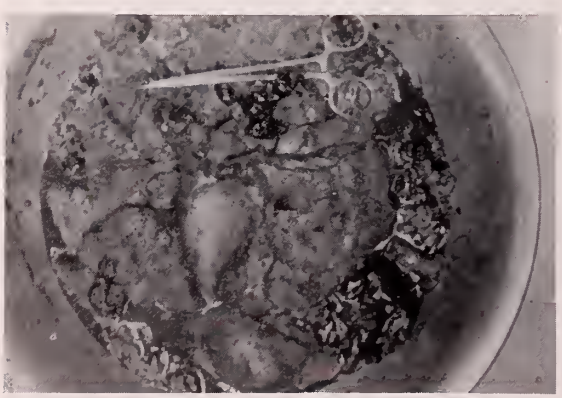


Fig. 4. Case 2. — Contents of aneurysm, illustrating clots in various stages of organization.



Fig. 5. Case 2. — Bifurcation graft constructed from two thoracic homografts showing no leakage at four sites of anastomosis even when under 30 pounds of water pressure.

Davis, Grove and Julian[21] in 1956. Successful treatment of ruptured aneurysms has been reported by Cooley and De Bakey[22] and Farrar and his associates.[23] Certainly, our patient with all these troubles did not truly represent his home address, which was, ironically, "Lucky Drive." Patients in other cases in our presentation could more appropriately have claimed that address.

Still another unusual problem encountered in our practice was that of unilateral nephrectomy having been performed in three patients who presented themselves for abdominal aortic surgery, one with the Leriche syndrome and two with aneurysms. Ordinarily, cardiac disease and renal disease constitute the chief contraindications to surgery.[24] It is not unusual for many of the patients to present these difficulties, as in cases 1 and 2, because of the nature of the disease and the age of some of the patients. Such extensive surgery in patients with only one kidney presents a problem that may be particularly acute if the remaining kidney is diseased.

Case 3. — The first of these patients was a 42 year old white woman with occlusion of the aortic bifurcation. At the time of hospitalization in December 1956, she had the classical complaints of pain in the back and hips and claudication in the legs for three years, of such severity that she could hardly walk across a room. There was a history of recurrent kidney infection and stones since the age of 16 years. Calycectomy on the right side had been performed at Orlando in 1950 because of "pyelonephritis." She had been admitted to St. Vincent's Hospital in Jacksonville eight times since July 1953, the last admissions being as a service patient. Five of these admissions were for urologic treatments, the first and major one of which was left nephrectomy in July 1953 for pyonephrosis and nephrolithiasis. Subsequent treatment usually included cystoscopy and dilatation of a stricture at the right ureteropelvic junction.

In September 1956, she emphasized the weakness of her legs, the easy fatigability and claudication so much that surgical consultation was obtained. An alert resident, Dr. James Bond, discovered the absence of femoral and pedal pulsations and performed an aortogram, which

demonstrated blockage of the distal aorta and proximal common iliac arteries with prominent collateral circulation. The blood urea nitrogen level was elevated to 36 mg. per hundred cubic centimeters, and there was much albumin and pus in the urine. She was treated conservatively and observed for three months with slight improvement of renal function, but with increasing severity of the vascular symptoms.

Conferences with internists, urologists and surgeons resulted in a decision to advise surgery. It was believed that the renal disease was of long duration and relatively static, but that the aortic occlusion was progressing so much that the patient desired and needed relief. A concentrated effort was made to improve kidney function with a degree of success. The preoperative blood urea nitrogen level was 17 mg. per hundred cubic centimeters. The right ureter was catheterized preoperatively by the urology resident, Dr. William Hutchinson. On December 20, an aortic bifurcation homograft was used to bypass the occluded segment (fig. 7), extending from the aorta proximal to the complete blockage to each common iliac artery distal to it. There was severe atherosclerosis of the vessels so that more endarterectomy was performed on each than is desirable. This amounted to several centimeters in the right common and external iliac arteries, in which the condition was the most severe.

The bypass procedure was decided upon in order to reduce the operating time for such a poor risk patient. The circulation in the right leg was not as good as desired, and an additional ileofemoral bypass would have been inserted had the patient been in better condition. Femoral pulses were palpable bilaterally, but the pedal pulses were not palpable on the right. The preoperative blood pressure was 90 systolic and 60 diastolic, unusually low for this disease, and most likely accounted in part for the weak peripheral pulsations postoperatively.

The postoperative course was surprisingly uneventful. The catheter was left in for several days, and adequate urinary output and hydration were maintained with intravenous fluids. The right leg now has the better circulation with better femoral and pedal pulsations than the left leg. The patient can walk two or three blocks before noting claudication in the left leg. Her condition is gradually improving, and she is quite happy.



Fig. 6. Case 2. — Saccular aneurysm of proximal aortic arch with dissecting aneurysm of innominate artery (at tip of left index finger). Thrombosis of the left subclavian artery is visible just opposite the right index finger.

Cooley[25] has performed bypasses of bifurcation occlusions with satisfactory results and without additional pain, vasospasm and thrombosis,



Fig. 7. Case 3. — Aortic bifurcation homograft bypass in situ.



Fig. 8. Case 4. — Excised aneurysm with contents.

which were formerly thought to be important reasons for excising the involved segments. Apparently, a major shunt in such a large vessel serves as a deterrent to further stagnation and thrombosis. Interestingly enough, the patient in this case brought her brother in a few days ago for examination because of symptoms somewhat similar but milder than hers. Fortunately, he has two kidneys.

Case 4. — A 58 year old white man had complained of epigastric pain almost constantly since its onset following use of a pneumatic drill while at work at the Naval Air Station in 1954. The pain was aggravated by exercise and was associated with exertional dyspnea without orthopnea or other evidence of cardiac decompensation. An aneurysm was discovered by Dr. James Sinnett, a resident at St. Vincent's Hospital, when he was on duty at the Naval Air Station in 1954. Cholecystectomy was performed for cholelithiasis by others at St. Vincent's Hospital in 1954, at which time the aneurysm was noted, but no therapy was undertaken. The pain had become steadily worse in recent months, with severe exacerbations occurring at times. Nephrectomy on the left side had been performed in 1951 by the McIver Clinic for massive nephrolithiasis. Recent renal studies by Dr. Robert J. Brown revealed satisfactory function of the remaining right kidney. The urine showed good concentration, 4 plus albumin, and 3 to 4 red blood cells, 0 to 2 white blood cells and several coarse granular casts, when first examined in our office. The hematocrit reading was 53 per cent, the hemoglobin estimation 11 Gm., and the blood urea nitrogen level 11 mg. per hundred cubic centimeters.

The patient was studied thoroughly by an internist, Dr. Lawrence E. Geeslin, who collaborated with the urologists, Dr. Brown and Dr. William A. Van Nortwick, and us to decide that in view of persistent pain and progressive enlargement of the aneurysm, as demonstrated on roentgenograms of the abdomen and by palpation of the 10 by 8 cm. pulsatile mass, surgical therapy was advisable. One week of preoperative preparation was recommended to allow preparation for surgery, with particular emphasis on the kidney. The albumin disappeared from the urine. Opiates were necessary to control back and epigastric pain. The blood pressure in the upper extremities varied from 150 systolic and 90 diastolic to 170 systolic and 120 diastolic. The pulsations were decreased in both lower extremities, with absent dorsal pedal pulses on the left and posterior tibial pulses on the right.

At exploration on Jan. 22, 1957, a large arteriosclerotic aneurysm of the abdominal aorta was found (fig. 8).



Fig. 9. Case 5. — Small aneurysm in situ before complete excision.

It originated sharply from just below the origin of the right renal artery and terminated abruptly just above the aortic bifurcation. There was erosion of vertebral bodies posterior to the aneurysm. Both common iliac arteries were diffusely dilated down to and including the external iliac arteries. The left kidney was absent; the right kidney was of normal size and consistency.

The aneurysm was resected with difficulty because of adhesions to the vena cava and the right renal artery. One small branch to the right kidney was sacrificed, as was the inferior mesenteric artery, the usual procedure. An Edwards-Tapp nylon prosthesis[26] was inserted from 2 cm. below the renal artery to 1 cm. proximal to the bifurcation. The peripheral arteries showed advanced atherosclerosis, but the lumen was patent. The blood flow into the lower extremities was fairly good. The postoperative course was uneventful. Adequate hydration and urinary output were maintained by intravenous fluids and electrolytes for five or six days. The peripheral pulsations remained as good or better than before the operation. The maximum blood urea nitrogen level was 46 mg. during the postoperative period.

The patient was permitted to return to "light work" on March 7. After one month, it was learned that there was no light work associated with his job at the Naval Air Station; so he had performed full work without difficulty other than occasional aches and pains. He is relieved of his severe pain and takes no more narcotics.



Fig. 10. Case 5. — Interior of excised aneurysm illustrating ulcerations with softening and thinning of wall.



Fig. 11. Case 5. — Edwards-Tapp nylon prosthesis anastomosed to lower abdominal aorta.

This case represents the rehabilitation of a completely disabled patient who suffered from progressive disease which likely would have caused his death, but who might easily have been refused surgery on the basis of disease of the remaining kidney.

Case 5. — A 60 year old white woman was first seen by us on April 19, 1957, with a medium-sized abdominal aneurysm known to have been present for two years. Recently, she had experienced episodes of abdominal pain to the left of the umbilicus, and this region was more tender to palpation.

There was also a history of long-standing genitourinary disease. In 1928, a urethral furuncle was removed. Since then she had required periodic urethral dilatations. In October 1942, she was under the care of Dr. Robert B. McIver because of low back pain and frequency of urination of two years' duration. Calculous pyonephrosis of the right kidney necessitated a right nephrectomy. Since this procedure, the patient has had no further serious urinary difficulties, but she has required urethral dilatations. She has had moderate hypertension for several years, which has responded satisfactorily to hypotensive agents prescribed by Dr. Simon D. Doff.

Physical examination revealed a well developed and well nourished woman appearing younger than her stated age of 60. A tender, lemon-sized pulsating mass was present in the periumbilical region, slightly to the left of the midline. Peripheral pulses were satisfactory. Soft tissue roentgenograms of the abdomen clearly outlined an aneurysm in this location. Repeated urinalyses showed concentration to 1.015 and no albuminuria or pyuria.

Surgery was performed on April 21. The urethra required dilatation before insertion of an indwelling catheter on the operating table. The patient had been prepared with urinary antibiotics and a high fluid intake, so that the preoperative blood urea nitrogen level was 15 mg. per hundred cubic centimeters. The section and the excision of this aneurysm were not particularly difficult because of its relatively small size (fig. 9). It contained several areas of softening and thinning of the wall (fig. 10). It ended abruptly just above the bifurcation and required only a linear Edwards-Tapp nylon graft for replacement (fig. 11). The occlusion time was one hour and 35 minutes. The postoperative course was uneventful. The blood urea nitrogen level rose to a height of 33 mg. per hundred cubic centimeters during this period.

It has long been known that aneurysms act as a persistent hammer when adjacent to bone, frequently eroding through it and causing a considerable degree of pain as in case 4. Another case is briefly presented to illustrate dramatically this characteristic (fig. 12). The patient was not ours; she was presented at a conference at the Duval Medical Center where she was a patient.

Case 6. — A 65 year old Negro woman had a history of syphilis and a mass on the anterior wall of the chest for two years. Because "it bled a little for two days," she presented herself with this large aneurysm protruding through the anterior wall of the chest. It had the appearance of a "mid-breast" (fig. 12). It had eroded completely through the sternum. There had been necrosis of the skin over the most distal part of it with clotting, the dislodgement of which might cause "considerable excitement." Surgery was performed on this patient at the Duval Medical Center by the surgeon on service. Unfortunately, hemorrhage ensued, and she expired on the operating table.

Aneurysms of this type are comparatively rare, are usually of syphilitic origin, and as a rule do not require transection of the aorta or grafting. Since they are saccular in type, the sac can be excised and aortorrhaphy performed. As would be expected, the dissection is treacherous.

Discussion

Acquired arterial diseases present a problem as old as medicine itself. Their complications emphasize the seriousness of the "do-nothing" treatment. It is not surprising that medicine and surgery have progressed so rapidly in the past few years in treating such diseases, but it is appalling that we men of science have come so slowly in dealing with this particular field. According to Shumacker,[27,28] as long ago as 1761 Lambert of



Fig. 12. Case 6. — Saccular aneurysm of ascending aorta with erosion through sternum and anterior chest wall, revealing fresh clots on surface secondary to recent "little bleeding."

England reflected in a letter to Hunter the hope "that a suture of the wound in an artery might be successful." At his suggestion Hallowell accomplished closure of a small rent in an artery by twisting a thread about a pin placed through the lips of the wound. Approximately 200 years passed before we were able to fulfil his hopes with reasonable safety.

It is to be hoped that we can reduce the incidence of acquired arterial diseases and their complications by preventive medicine, but first we must determine the basic causes for their existence. In the meantime, let us become more conscious of the existence of these diseases so that we may recognize them and treat them before disabling and fatal consequences develop.

Too often we surgeons are more afraid of our statistics than of our patients' disease. Sometimes we may be afraid of the procedure itself, and on occasion rightly so. We have refused surgical aid to patients with the excuse that the vessels were too poor to withstand surgical anastomosis. De Bakey and others have succeeded in exploding this fallacy, having turned down no cases in recent years for this reason. Certainly severe cardiac, renal and other diseases sometimes forbid surgical procedures of any kind, but let us not withhold treatment without thorough study and evaluation. Many of the patients with these diseases not only can tolerate the surgery, but can benefit enough from it to lead useful and happy lives. The expectant benefits must be weighed carefully against the involved risks, and the patient must be informed of the results. Each patient should be permitted to make a decision knowing all angles.

The fatal outcome in cases 1 and 2 of this series suggests more respect for the dangerous complications of the disease and more thorough consideration of the situation from all angles before withholding surgical aid. Despite hypertension, coronary disease and a cerebral accident, the patient in case 1 withstood total thyroidectomy without difficulty two months prior to death. On the basis of life expectancy of less than two years after diagnosis of an aneurysm, some experts might have recommended initial surgical attack on the three aneurysms present in this case. In case 2, the patient was likewise an extremely poor operative risk having multiple complications of arteriosclerosis. Nevertheless, had he consented to the removal of the aneurysm when it was first diagnosed and surgery had been undertaken then instead of as a last resort after its rupture, the fatal outcome might have been averted.

Cases 3, 4 and 5, in which the patients had previously been subjected to nephrectomy because of nephrolithiasis and associated infection, suggest that nephrectomy need not be a contraindication to definitive surgery of arterial occlusions and aneurysms in selected cases, even when the remaining kidney may show disease. The careful preparation of such patients for surgery usually calls for teamwork between the urologist, the internist and the surgeon.

Erosion of bone by an aneurysm is illustrated by cases 4 and 6. In case 4, the patient with one kidney suffered severe pain in the back due to erosion of vertebral bodies. A large aneurysm, in case 6, protruded through the sternum with necrosis and crusting of the distal skin. This type of aneurysm usually can be treated by excision and primary suture.

Patients with persistent problems relative to abdominal, pelvic, back or leg pain, fatigue, or weakness should be given the benefit of thorough investigation from a vascular standpoint. If peripheral pulsations are unequal or missing, further studies for localization of the disease should be insisted upon. Roentgenograms will usually reveal aneurysms, but aortography will be necessary to reveal thrombosed areas. Definitive surgery should be advised early if such a localized process is demonstrated.

Few drugs are of value in the treatment of such cases. Sympathetic surgery would simply delay more beneficial treatment in most cases. If an appreciable vasospastic element is present in patients with complications of arteriosclerosis, sympathectomy can be performed at the time of aortic surgery.

Synthetic prostheses offer great promise as substitute grafts for the large arteries, but they do not yet completely replace arterial homografts. Both should be available when such surgery is electively undertaken.

Legal complications and family misgivings must be overcome if we are to maintain an adequate supply of homografts. This calls for doctor cooperation. Physicians who lose patients under 45 years of age from accident or disease can do a great service by obtaining an autopsy with permission for use of the large arteries. It can be considered a fitting memorial to a lost loved one to permit the use of the large arteries to be a life-saving measure for another.

Summary

A series of cases is presented which illustrates advanced arterial diseases and their complications. In two cases there were multiple complications, with both thrombotic and aneurysmal components. One terminated fatally from mesenteric thrombosis due to ascending fresh thrombus above a bifurcation occlusion and the other from rupture of a huge aneurysm of the abdominal aorta.

Three cases illustrate successful aortic grafting in patients with only one kidney. In two of these cases there was evidence of disease in the remaining kidney. Careful preparation for surgery in such cases is stressed.

Two cases present a common characteristic of aneurysms, bony erosion. One illustrates the relatively rare picture of erosion of the aneurysm through the anterior wall of the chest with presentation on the chest.

A plea is made that physicians become more "vascular conscious" so that these diseases will be diagnosed and treated before serious complications develop.

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Erratum

On page 252 of the September issue of The Journal of the Florida Medical Association, the statement is made to the effect that the virus diagnostic laboratory of the University of Miami School of Medicine Department of Bacteriology and the Variety Children's Hospital is the only comprehensive facility for service and research in the virus diseases in Florida.

The University of Miami School of Medicine has advised The Journal that Dr. Albert V. Hardy, Director of the Bureau of Laboratories, Florida State Board of Health, has called attention that the Florida State Board of Health at Jacksonville also has a virus diagnostic and research laboratory. The laboratory is supported by research grants from various federal agencies and some state funds.

Reconstructive Arterial Surgery

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The entire field of vascular surgery has mushroomed during the past 15 years. Reconstructive arterial surgery, although perhaps one of the older and more established facets of vascular surgery, has shared in this tremendous development. In large measure, the basic principles of arterial surgery were meticulously formulated during the early portion of the twentieth century, but it was not until late in the forties and early fifties that the lessons learned by the surgical pioneers in this field could be put into everyday use. The vast amount of experimental work in the field of arterial transplants and preservation of homografts has completely revitalized arterial surgery. The most important and far reaching result of this work is the fact that this surgery can now be performed, and should be performed, in any major hospital in the United States. It therefore behooves every individual physician to understand thoroughly and recognize the various arterial lesions amenable to surgery, the essential diagnostic steps and the anticipated results. This is a rapidly changing field, and unless he keeps abreast of these changes, his patients will not receive the best of treatment.

Some of the more common situations needing to be discussed will be illustrated in the cases to follow. In general, they are the result of trauma, degenerative diseases, or mechanical obstructions. As mentioned, corrective surgery of all these lesions has been tremendously dependent upon the development of arterial substitutes and methods in the preservation of homografts. During the past five years, numerous experiments have shown that living arterial tissue is not essential in reconstructing an arterial pathway; furthermore, homografts may be used successfully after being obtained as long as 12 to 24 hours postmortem. Such grafts are now commonly sterilized by irradiation or by chemical means. Our community is well serviced by an Artery Bank, which obtains all its vessels from the pathology service of a 400 bed hospital. These grafts are sterilized by a chemical, beta-propiolactone, and then temporarily preserved for one month in a balanced salt solution. Equipment is also available commercially by which these vessels may be freeze-dried and preserved indefinitely. Thus the availability of a substitute artery is no longer a problem in moderate-sized communities as long as the products of Detroit continue to decimate the population, the only problem lies in the actual physical removal and preservation of the arteries. Its solution requires a small amount of initiative and a minimum of work and equipment.

Inasmuch as one is dealing with an unknown factor in the ultimate fate of this dead tissue acting simply as a strut for an arterial pathway, attention has also been directed towards perfection of a fabric prosthesis which might supplant the homograft. Of the fabrics in general use, nylon, particularly in the crimped form, has been most popular, although dacron has been shown recently to have many more advantages. Since there has been extensive duplication of effort throughout the country in this work, a committee has been established by the American College of Surgeons and the Society of Vascular Surgeons to organize and simplify further experiments. For the present, it is generally conceded that the homograft gives distinctly better results in small artery replacement, although both the fabric graft and the homograft have equal advantages in replacing portions of the aorta and iliac arteries.

Trauma

To return now to the clinical application of these grafts, military and civilian experience of the past few years has shown that all acute arterial injuries should be treated immediately by corrective arterial surgery, either by direct reanastomosis, or insertion of a graft where loss of arterial substance is extensive. The tremendous increase in salvage of extremities and prevention of amputation in the Korean conflict are directly attributable to the adoption of such surgical

Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 7, 1957.

principles. It is no longer permissible to stand by, placating one's feeling of helplessness with sympathetic blocks and vasodilators; a pulseless extremity in the presence of recent trauma demands immediate surgical exploration.

The same principles apply in the treatment of post-traumatic arterial aneurysms and arteriovenous fistula. Such lesions are frequently missed initially, or immediate surgical attention is lacking. An example of the latter situation concerns a machine operator who was injured in the right thigh by a deflected piece of steel from a chisel. First aid with control of superficial bleeding was rendered, and when referred for surgery three weeks later, the patient had ample evidence of a false aneurysm and a fistulous communication between the superficial femoral artery and vein. Immediate surgery with excision of less than a centimeter of artery, reanastomosis, and closure of the laceration in the vein returned this patient's vascular system to a normal status, as evidenced by postoperative arteriograms, and return to full work in three weeks. Following the old practice of delaying surgery for six weeks to three months awaiting the development of collateral circulation would have made this case unnecessarily complicated. The increase in size of the aneurysm probably would have made grafting a necessity, and the continuing presence of the fistula would certainly have had a decided effect on the patient's cardiac status.

In my opinion, the old premise of delayed surgery in the treatment of such lesions is no longer tenable; too much can be gained with less risk by immediate or early surgery. Furthermore, the success of grafting procedures in major arteries of the extremities has made obsolete the practice of quadruple ligation of an arteriovenous fistula. There is no need in salvaging an extremity only to have incapaciting claudication when one can reconstruct the arterial pathway and end with a normally functioning limb.

A second example of arterial injury concerns an eldery man who struck the inner aspect of his thigh on a swimming pool. A persistent and enlarging hematoma was finally diagnosed correctly, and a femoral arteriogram corroborated the palpatory diagnosis of a massive false aneurysm. Since the lesion was at least three months old, it was thought that surgery could be performed on an elective basis. Sudden extension of the aneurysm and occlusion of the distal superficial femoral artery, however, completely overruled this decision and made emergency exploration imperative. Removal of the aneurysm, and reconstruction of the superficial femoral artery with a 3 inch crimped nylon graft produced a viable, normally functioning leg. Procrastination with sympathetic blocks, intra-arterial injections, or vasodilators might well have cost this patient his life, let alone his leg.

Degenerative Diseases

A much more serious condition confronts one in the surgical correction of the abdominal aortic aneurysm. Although there is not complete unanimity of opinion concerning the prognosis of cases of this type, most physicians agree that about 50 per cent of the patients will expire within two years and 80 per cent within five years of diagnosis. The majority of these deaths are due to rupture of the aneurysm. It is our belief that once a diagnosis of an abdominal aneurysm has been elicited, a most careful evaluation should be made concerning the patient's probable future. If he is not likely to die within a three to five year period of other causes, then the aneurysm should be considered as grave as a malignant disease and dealt with promptly.

At this point I should like to emphasize the word promptly. If a patient with an aneurysm is allowed to become symptomatic from the standpoint of back and abdominal pain, the risk of surgical correction is significantly increased. An example is found in the case of a 56 year old man referred to a urologist for investigation of a kidney tumor. The patient was shunted from one doctor to another over a six month period in an effort to get relief from severe back pain. By the time he was seen by the urologist, abdominal pain had likewise become a major factor. Exploration following completion of the correct diagnosis revealed a medium-sized aneurysm with almost complete overlapping of the vena cava and extensive erosion of the vertebral column. The latter was so severe that the proximal aorta had to be occluded twice as long as ordinarily preferred and the aneurysm actually cut away from the vena cava and vertebral column. Postoperative discomfort in the leg due to prolonged loss of blood supply was severe, although temporary; this, plus the danger of severe hemorrhage during the dissection, could have been obviated by diagnosis and treatment at a much earlier stage. Fortunately, diagnosis can be, and frequently is, made before the onset of symptoms;

it is at this point or at the beginning of symptoms that maximum attention should be paid to arriving at a decision for surgical treatment.

Abdominal palpation and lateral roentgenograms of the abdomen are the two most important diagnostic means. Mobility of the aneurysm as shown by palpation offers an excellent clue as to the ease of removal. Operability, however, cannot be determined by palpation alone; many resectable aneurysms appear to extend up under the xiphoid cartilage. Fortunately, less than 10 per cent of the abdominal aortic aneurysms involve the aorta above the renal arteries. The lateral roentgenogram frequently reveals the configuration of the aneurysm because of calcification in its wall and is thereby helpful in determining the proximal extent of the lesion. It is now generally agreed that aortograms do not add sufficient information concerning the extent or operability of an aneurysm to warrant their definite risk.

Although our experience in this field is not large enough to be significant from the standpoint of figures, it is ample enough to warrant forming certain conclusions. As mentioned, we believe that it is a mistake to clamp off the aorta at the beginning of dissection; to do so may aid in the removal of the aneurysm, but prolongation of lack of blood supply to the lower extremities will be much more detrimental to the patient. I have found little difference, except for two factors, between homografts and the crimped nylon bifurcation graft. The former are easier to work with and certainly far more adaptable to unusual situations. Also, the lack of elasticity in the proximal end of the nylon graft may have an ultimate detrimental effect on its continued patency. I strongly favor the use of dilute heparin solution in large quantities injected both proximally and distally in the aorta and iliac arteries; our zero incidence of postoperative graft occlusion at this level is certainly due in some measure to this technic. We believe that the current mortality statistics of 10 to 14 per cent as reported in the large clinics are favorable when one considers the malignancy of the primary lesion and the general age group in which this condition prevails. The sharp rise in immediate mortality to 40 or 50 per cent for those patients surviving perforation of an aneurysm long enough to reach the operating room only emphasizes the need for an early decision as to surgical therapy for abdominal aortic aneurysms.

There is another complication of atherosclerosis involving the abdominal aorta similar to aortic aneurysm only in etiology. This consists of luminal obstruction of the aorta plus one or both iliac arteries; the symptoms produced are frequently referred to as the Leriche syndrome. Patients with this complication have unilateral or bilateral paresthesia and claudication involving the hips, thighs and ultimately the entire legs, depending on the site of the obstruction. Diminished to absent aortic pulsation and absent femoral pulsations make the diagnosis fairly simple. An aortogram is helpful in delineating the proximal level of obstruction; it is of more importance, however, to visualize the distal circulation to be sure of its patency. Visualization may be accomplished with delayed films at the time of the aortogram or by femoral arteriography.

Interestingly enough, a sufficient number of the patients with this condition may be in their fourth decade of life, and surgical correction is thus of much greater importance than in an elderly patient who does not need to do extensive walking in order to make a livelihood. Resection and grafting of the obstructed aorta and common iliac arteries will frequently return these patients to a normal exercise tolerance. Two of our patients had such intense claudication that they were practically unable to walk from their bed to the bathroom. Reconstruction of their obstructed circulation has resulted in complete relief of claudication even under conditions of severe exercise.

In some clinics the opinion is held that better results are obtained by reaming out the atherosclerotic deposit within the aorta and iliac arteries, and then reclosing the incision in these vessels. We have not used this maneuver and are unable to comment on its usefulness. Certainly, resection with grafting has been successful in a high percentage of cases. Unfortunately, a certain number of the patients have involvement up above the renal arteries making grafting or endarterectomy hazardous. What the ultimate proper procedure for these cases will be remains to be seen.

One of the problems in reconstructive arterial surgery still not completely answered concerns the patient with atherosclerotic obstruction in the arteries of the lower extremities. In general, we see two essentially different types of patient in this group. The first type is usually in the sixth or seventh decade of life, and will have a history of claudication involving one or both calves of a significantly long duration. The onset of pain

is gradual and progression slow. Femoral artery pulsations are usually present, but diminished in amplitude, and the popliteal pulsation is characteristically absent. Oscillometric measurement in the upper part of the thigh will be reduced to one and a half or two units, and in the lower portion will show no fluctuation. Roentgenograms of the extremities will probably show extensive spotty calcification from the iliac arteries down to the popliteal bifurcation. These patients have generalized atherosclerotic deposits, and in our opinion are not candidates for any present day form of arterial surgery. Involvement of the branches of the popliteal artery by their primary disease will automatically result in obstruction of any arterial graft placed above this level. Their only benefit from a surgical standpoint will come from a lumbar sympathectomy.

The second type of patient differs in that there is a history of claudication which is relatively acute, and progression of symptoms is rapid. The femoral artery pulsation and oscillometric measurements of the upper part of the thigh are usually normal. A block can easily be demonstrated, usually in the mid or lower third of the superficial femoral artery by palpation or oscillometric measurement. Roentgenograms usually will show no calcification in the femoral vessels. The most important diagnostic method consists of a femoral arteriogram to delineate the level of obstruction, and, of far more importance, to show the patency of the outflow system below the obstruction. Generally, the popliteal artery and its branches are normal. In essence then, this type of patient has a localized segmental block, which can usually be overcome by reconstructive surgery. At the present time, it is generally agreed that a bypass graft which leaves the obstructed artery in place and simply detours blood down to the outflow artery is the best method. The collateral circulation already developed is not distributed by this plan. Judging from reports from the larger centers, about 70 per cent of grafts of this type will remain patent over a two year period; some clinics are reporting a 50 per cent salvage of extremities in the early stages of gangrene by this method. Another technic reported in the literature giving considerable success is that of endarterectomy of the obstructed femoral artery; success here is again dependent, however, on a patent outflow tract.

Emboli

When arterial continuity is interrupted, a different situation exists. Aortic or peripheral arterial emboli, whether derived from auricular thrombi or calcific aortic plaques, carry a mortality of over 20 per cent and a loss of limbs of over 50 per cent. In general, most emboli will lodge in the lower portion of the aorta or in the common iliac arteries. Sudden occlusion of the superficial femoral artery is usually associated with a pre-existing area of atherosclerotic narrowing. The surgical attack upon aortic or arterial emboli is directed towards direct removal of the embolus and the thrombus associated with it. This is accomplished through an arteriotomy at the proximal level of obstruction. The recently revived method of flushing out thrombi from the peripheral arterial bed by means of retrograde injections of heparin solution has resulted in an even higher rate of successful salvage of extremities. With proper technics this now approaches 70 per cent.

It has been amply shown that the success of embolectomy is enhanced the shorter the duration of the process and the less distal the thrombus present. There are, however, many cases recorded in which successful removal occurred after as much as 24 to 48 hours had elapsed.

One example of delayed removal concerned a 50 year old postal employee who suffered from recurrent auricular fibrillation. While working one day, he suddenly found that his right arm became useless while pitching letters into containers. After a few minutes' rest his arm strength returned only to be lost on resumption of activity. He was found to have an embolus in the axillary artery just beyond the anterior humeral circumflex branch. The latter was sufficient in providing enough blood at rest, but exercise produced almost immediate arterial insufficiency. Removal of the embolus by simple arteriotomy returned this man to his work with no residual claudication. Certainly the situation of sudden arterial obstruction by emboli demands immediate attention. It is of maximum importance not to procrastinate just to see whether or not gangrene will supervene. A curative surgical procedure will offer far more than watchful waiting.

320 North Main Street.

(A discussion of this paper by Dr. Francis N. Cooke may be found on the following page.)

Discussion

FRANCIS N. COOKE, Miami: Dr. Moody has presented an extremely important subject and one that I have been actively interested in for many years. I wish to congratulate Dr. Moody on his most informative presentation.

Blood vessel replacement therapy is today no longer in its experimental or developmental phase. On the contrary, the methods and technics now utilized have stood the test of time and are currently accepted as being on a firm footing. This modality, therefore, I believe is a most valuable addition to our medical armamentarium.

This slide represents our experience to date. The total number of cases in which blood vessel transplants have been used is 48. These cases are divided into the significant anatomic regions because of the problems peculiar to those particular areas.

Nine of these transplants have been autogenous vein grafts, and these of course have been used only in the peripheral vessels where short segments of the artery are involved, such as traumatic aneurysm or arteriovenous fistula. Bullet and knife wounds usually account for most of these, as in the case Dr. Moody illustrated.

The great majority of our transplants have been homologous arterial grafts. Only two are plastic material—one of Vinfon N and one of Dacron taffeta which I bought at Sears Roebuck.

Results.—In cases involving the thoracic aorta, we have had three deaths, a 50 per cent mortality, which is too high. The average life of a person with intrathoracic-aneurysm, however, is six to eight months, and in uncomplicated cases I believe we can improve on this considerably. We have had four cases of ruptured aneurysms of the aorta, and we have saved two of these with emergency surgery. These are difficult cases to manage.

In the cases of elective resection of the abdominal aorta, there have been two deaths, an operative mortality of 11.7 per cent, which compares favorably with most of the published series throughout the country.

I believe, however, the important thing to consider is the long term results of this type of therapy. What does the future hold for these patients?

For those patients who survive the operation for aneurysm, the results have been excellent. In all of these cases blood flow to the extremities has been re-established, and the grafts have functioned well.

In obliterative arterial disease with skip areas of arterial occlusion, long term results have not been good, as with aneurysm. Nevertheless, they are considered good. We must realize that the arteriosclerotic process is diffuse and progressive and that blood vessel replacement therapy does not alter the course of the systemic disease. For this reason, patients must be carefully selected. Carefully performed angiograms are an absolute necessity for proper assessment of the problem.

In my experience endarterectomy—removal of the organized thrombus along with the blood vessel intima—is of value in only a few cases and can be extremely dangerous if the clot reforms and propagates.

Lumbar sympathectomy for claudication has little value in obliterative arterial disease. For this reason I rarely recommend such a procedure.

Blood Vessel Banks

JOHN H. TERRY, M.D.
AND
JOHN B. ROSS, M.D.
JACKSONVILLE

Since major vascular surgery is now being performed in several cities in Florida, The Journal of the Florida Medical Association has requested that current information about blood vessel or artery banks in the state be published so as to acquaint all physicians with the facilities available to them. The scientific papers on complications of aortic disease and reconstructive arterial surgery which are published in this issue of The Journal cover well the diagnostic and therapeutic aspects of major vascular disease. Thus, each patient who undergoes a resection of a major vessel for congenital or acquired disease receives either a preserved homograft or one of the approved synthetic substitutes as a new vessel if primary suture cannot be accomplished. More than six years have elapsed since the first homograft vessel was implanted for acquired disease of the aorta. As early as 1948, homografts were used to bridge defects in such congenital diseases of the aorta as coarctation. A brief look at the accepted methods by which these vessels are obtained and processed is in order.

Blood Vessel Banks in Florida

At the present time, laboratories are equipped to prepare and preserve arteries obtained for therapeutic purposes in the Jacksonville, Orlando and Miami Blood Banks. While the present facilities in the state are in these three banks, it is anticipated that other hospitals, laboratories, blood banks and medical centers will be interested in forming artery banks. For this reason, some of the difficulties encountered in this endeavor will be enumerated as part of this discussion.

Preliminary Steps

Information received from a number of laboratories throughout the country indicates that certain general procedures have been widely adopted while others have been discarded. Most artery banks are sponsored by local chapters of such organizations as the American Heart Association and the American Cancer Society. Funds to purchase the necessary equipment for lyophilization may be forthcoming from such sources.

It is most important to consider in detail certain problems which are better solved before the first homograft is obtained. Approval of such a program by the county medical society and the formation of an artery bank committee with equal representation from all local hospitals constitute a portion of the major groundwork. This committee, then, should establish good rapport with the local Funeral Directors Association and the pathologists. Such cooperation can usually be obtained if the committee resolves to facilitate the embalming process by requiring insertion of small catheters into the ends of divided major vessels.

The legal technicalities vary to some extent in different localities. Since, however, the primary source of supply is potentially from the office of the medical examiner, it behooves interested physicians to achieve a high degree of cooperation with this office. Written permits to obtain vessels are likewise handled in different ways, depending upon the degree to which legal consultation is sought and the conformity of the individual hospital autopsy permits. In general, it is satisfactory to use the latter if an addition is made to cover the use of blood vessels for therapeutic purposes. It may be preferable, however, to employ special permits protected by proper legal advice.

In addition, trained personnel is needed to obtain the vessels as well as process them. A physician-delegate, a house officer, a pathologist, or a cooperative medical examiner is best able to remove vessels with minimal injury to them. Technicians may then clean the vessels and proceed with the sterilization process.

Procuring the Vessels

It is generally agreed that aortas should be removed from unrefrigerated bodies within six hours of death. The safe interval is 24 hours in bodies which are refrigerated within three to six hours of death. Persons 45 years of age or younger are likely to have acceptable aortas without disqualifying degrees of arteriosclerosis. There are some inconsistencies in available reports concerning other disqualifying conditions. Most authorities would reject bodies with certain generalized infections such as active syphilis, serum hepatitis, malaria, and generalized sepsis. Patients with proved collagen disease, generalized lymphoma, and malignant disease adjacent to the aorta should also be excluded.

The entire aorta from the proximal ascending arch downward is removed, including both common iliac arteries just beyond their bifurcation. The vessels can be removed during necropsy with little additional expenditure of time and no additional disfigurement. The specimen should be removed chiefly by sharp dissection from the anterolateral surfaces of the vertebral bodies so as to leave the branches at least 2 cm. long. If prior agreement with the Funeral Directors Association has been reached to obtain femoral vessels, these can then be procured through two incisions in the thigh. A single lengthy incision, however, will hasten this procedure. Small catheters may then be inserted into the iliac vessels, the profunda femoris, and the distal superficial femoral, or popliteal, arteries, and secured by a ligature for use by the mortician.

Processing

Once removed, the vessels should be placed in a bottle containing saline or Ringer's solution, and stored in a refrigerator. Vessels should not be stored at this stage in a freezer. Preferably the same day, although longer intervals may elapse, the vessels should be meticulously cleaned by blunt and sharp dissection by a physician or trained personnel. Tributary vessels should be left as long as possible and great care taken not to avulse these vessels at their base or to damage the intima.

The procedure most widely used at this time to preserve soft tissues such as blood vessels consists of three basic steps: first, sterilization; second, rapid freezing; and third, drying.

Sterilization

A number of methods have been used to sterilize vessels. Earlier, Formalin and Tyrode's solution were popular. More recently, high voltage cathode ray irradiation, beta propiolactone, and ethylene oxide have been used. Ethylene oxide is preferable if precautions against explosion are taken. The vessel is placed in a special sterile pyrex tube. Sufficient liquid ethylene oxide to fill the entire container is added and maintained for 30 minutes. This method must be used under a hood or in a fireproof cubicle because of the explosive properties of this agent. The excess ethylene oxide is then decanted off. A small segment may be taken for culture and microscopic study if desired.

Quick Freezing

Once sterilized, vessels may thereafter be preserved by one of two currently popular methods.



Fig. 1. — Sterilized and frozen graft, not dried.

In medical centers where the majority of vessels will be used in one institution, it is convenient to preserve the vessels in a frozen state. Thus, the sterilized vessel within the pyrex container is rapidly immersed in a mixture of equal parts of dry ice and alcohol (-75 C.) or acetone (-78 C.) for 15 minutes, and then placed for storage in a deep freeze until the moment of utilization (fig. 1). This quick freezing is said to produce much less cell damage by crystallization than occurs in slowly cooled material. It is believed that such grafts can be preserved for a period of at least one year.

Freeze Drying

The method best adapted to preservation in all situations and localities is that of freeze drying, or lyophilization. It consists of removing the protein-bound water within the vessel by the process of sublimation, or passage from the frozen state to gas. The proteins are not denatured in sublimation, provided it occurs below a critical temperature. A freeze drying unit consists of four basic elements:

(1) A vacuum system generally accomplished by the use of a mechanical oil-sealed rotary pump with or without the attach-

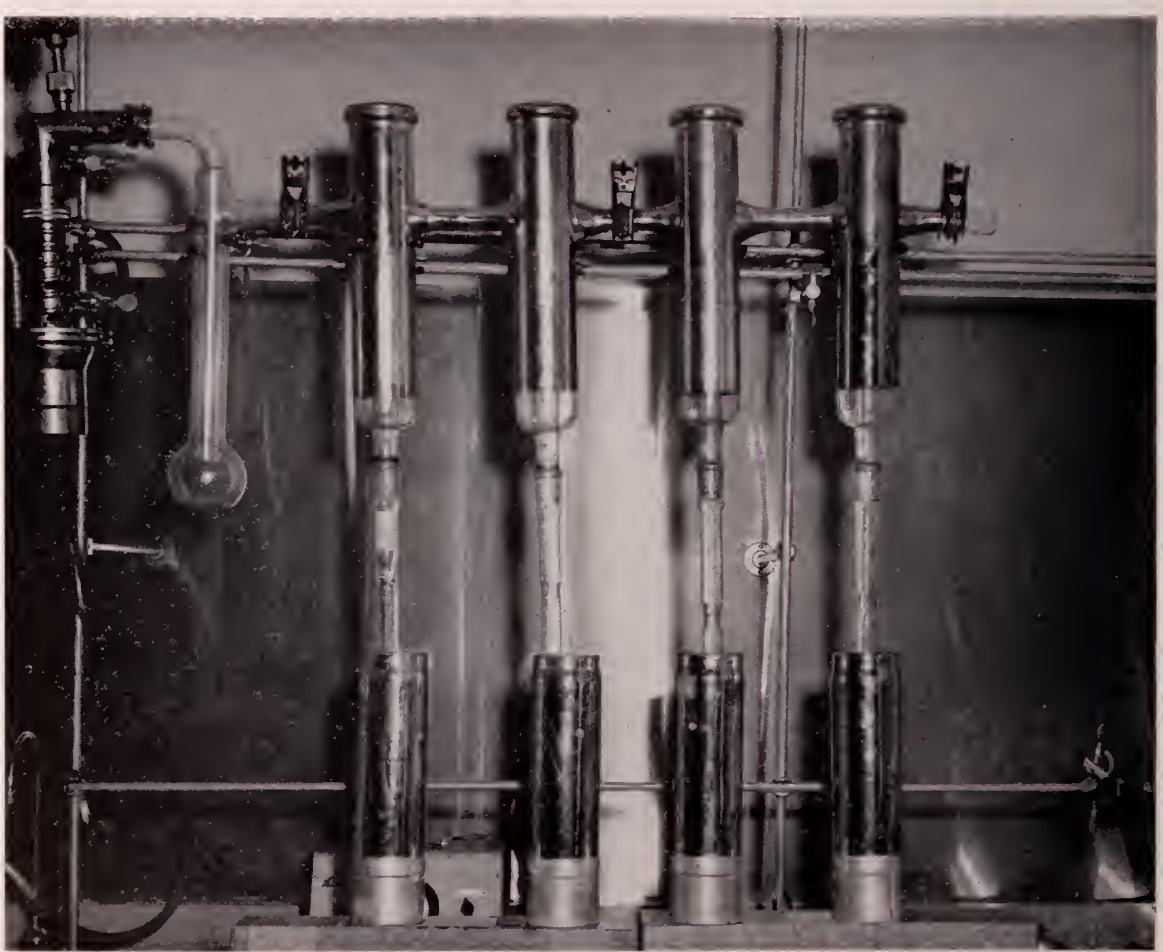


Fig. 2. — Hufnagel lyophilizing apparatus, with grafts immersed in dry ice and alcohol.

ment of an oil diffusion pump to augment the vacuum.

(2) A manifold connection to attach the flasks containing the frozen material to be processed.

(3) A condenser or cold trap, kept cold by an external refrigerant, connected between (1) and (2) to prevent water vapors from reaching the vacuum system, thereby reducing greatly its efficiency.

(4) A vacuum gage to measure the pressures in the system.

Thus, after the specimens are frozen in the dry ice–acetone mixture as described in step two, the container is connected to the system and the mechanical vacuum pump started. If the vessels have been sterilized with ethylene oxide which freezes at -111.3 C., liquid nitrogen must be used to cool the condenser and to solidify the sublimated ethylene oxide. It is convenient to keep the specimen frozen with the dry ice–acetone mixture during the early period of processing (fig. 2).

This process usually requires six to 10 hours if a satisfactory pump is available to obtain a pressure of 1 to 0.5 microns (fig. 3). Leaks in the system must be carefully avoided.

The last step consists of sealing the pyrex container and varies to some extent, depending upon the type of freeze-drying apparatus used. Usually, the tubes are sealed with an oxygen-methane torch. The graft is then ready for indefinite storage or early use (fig. 4).

Reconstitution

At the time of their use, the preserved grafts require a period of reconstitution in a sterile saline solution, preferably containing penicillin and streptomycin. If they are preserved by freezing alone, this period need only be for 10 to 15 minutes. At least 30 minutes of immersion, however, should be allowed for the lyophilized graft.

Availability of Grafts

Several of the larger artery banks in the United States, such as the Central Artery Bank of

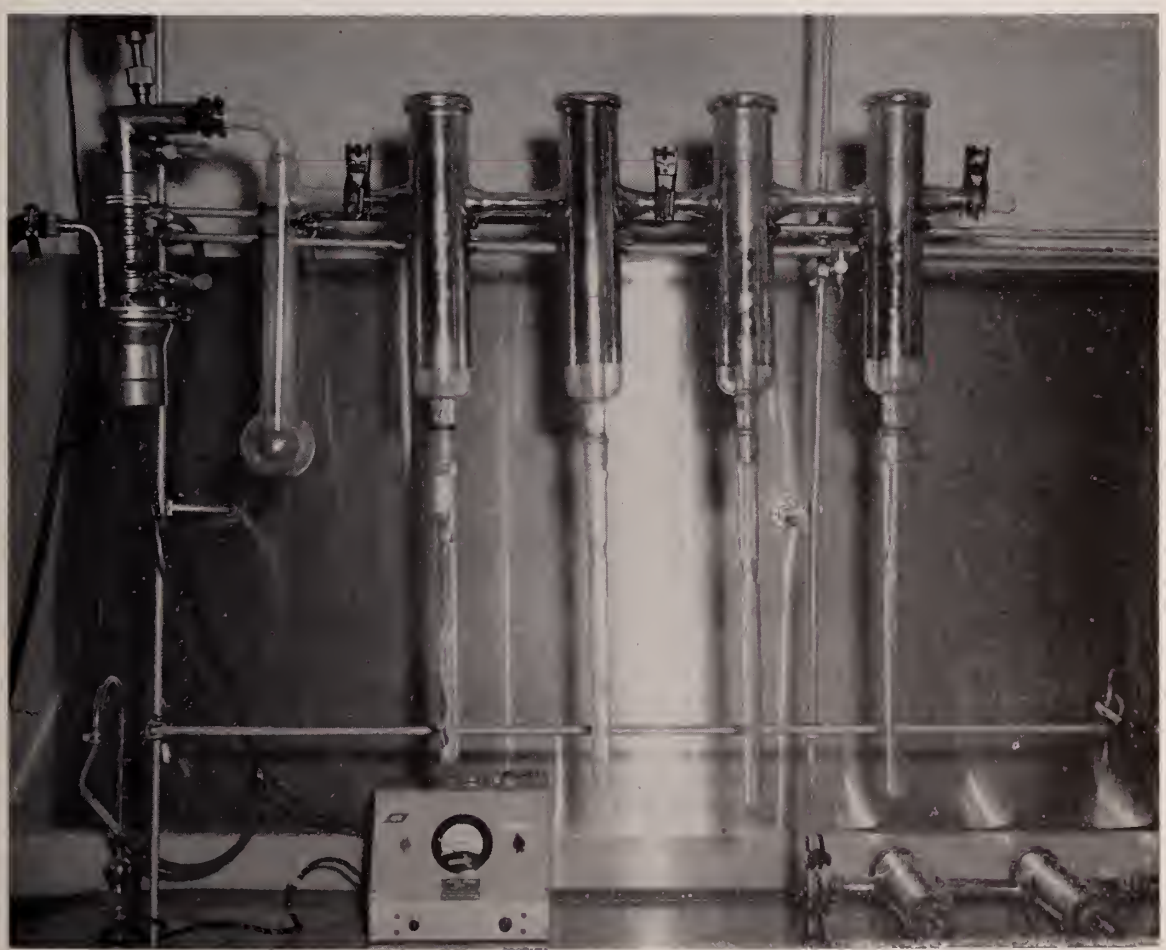


Fig. 3. — Hufnagel lyophilizing apparatus, with grafts nearing the final state of lyophilization.

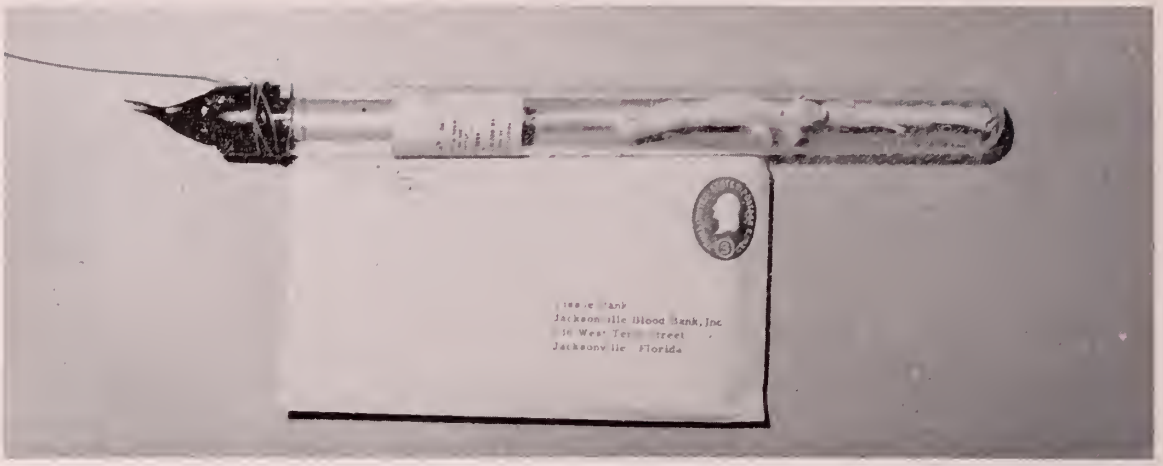


Fig. 4. — Lyophilized artery ready for storage or shipment.

Chicago and the Northern California Artery Bank in San Francisco, have established ambitious programs to supply vessels to rather large areas. Such a program can be carried out in Florida if the need exists. It would require distribution to "membership hospitals" of explicit details as to how the artery bank functions; how the vessels are obtained, shipped, and stored; the legal requirements; and the prerequisite that a vessel be donated for every one used in the local hospital.

At the present time any appreciable demand for vessels could not be met by the artery banks in the state. It is true that more and more synthetic prostheses are being used in preference to the homograft. Recent reports, however, of a variety of complications in the use of these substances in the smaller vessels should encourage Florida physicians to maintain and increase their interest in artery banks. Anyone desiring further information is asked to write to one of the banks in the state, or the Editor of The Journal.

Photographs supplied through the courtesy of the Tissue Bank, Jacksonville Blood Bank, Incorporated.

415 Medical Arts Building (Dr. Terry).
536 West Tenth Street (Dr. Ross).

Eleventh Clinical Meeting, American Medical Association
December 3-6, Philadelphia
Convention Hall
Headquarters, House of Delegates, Bellevue-Stratford Hotel

Fifty-First Annual Meeting, Southern Medical Association
November 11-14, Miami Beach
Auditorium

Clinical Report of an Unusual Contagious Exanthem

Ethel H. Trygstad, M.D.
NAPLES

During February and March of this year, in a group of children and one adult in Naples an exanthem developed which did not conform to any of the recognized entities. It was characterized by fever, headache, moderately sore throat, and a fine red rash beginning on the inner surface of the upper portion of the thighs and extending, in a few hours, over the abdomen, chest and back. A series of cases of a similar syndrome was reported from a children's orthopedic hospital in Pennsylvania.[1] The purpose of this report is to add certain details not noted there, and to direct the attention of Florida physicians to a disease which may be confused with scarlet fever.

In the 11 cases of the present series, all but one of the patients were pupils in one school, or familial contacts. The seven primary cases occurred in seven and eight year old boys; the younger brothers, aged five and two, and the mother of the boys and a 10 year old girl whose contact with any known case was not discovered, made up the total.

Headache was the usual initial symptom, quickly followed by fever, ranging from 100 to 103.4 F. On questioning, all admitted that their throats either were or had been sore. The 28 year old mother, who had the highest temperature, found the sore throat the most distressing part of the illness. About 12 to 24 hours after the onset, a fine, bright red papular rash was noted on the inner surface of the thighs, just below the crotch, and this rapidly extended up over the abdomen, chest and back; in some cases the extensor surfaces of the extremities were involved. No eruption was seen on the face, the palms or soles. One boy had some fine exanthem on the palate and buccal mucosa. The rash was moderately itchy.

The first two boys were seen after the throat symptoms had subsided and the rash was full-blown, suggesting an allergic dermatitis. Both had a history of allergic skin reactions in the past; so they were given an antihistamine, and a regimen of high calcium, vitamin C, low sodium and abundant fluids was recommended. The rash lasted three or four days. Eight patients seen early were treated with chlortetracycline or tetracycline. In these patients the rash did not extend as far, and both rash and sore throat cleared up in 48 hours. One boy received no treatment except local applications of an antipruritic lotion. The rash disappeared in about the same length of time as in those treated with antihistamines, et cetera.

The second and third cases in the one family began 10 and 11 days after the first, and the onset of the mother's symptoms occurred 10 days after these secondary cases, thus establishing a presumptive incubation period of about 10 days.

Slight desquamation was noted in the children with extensive rash. All patients made an uneventful recovery in two to five days, and no untoward sequelae have been noted up to the present.

Only one blood count was made, and this showed a hemoglobin estimation of 14.4 Gm. and slight leukocytosis (9,000) with normal distribution.

Nose and throat cultures showed a variety of organisms, including alpha and gamma type streptococci, hemolytic Staphylococcus aureus and yeastlike organisms. No beta hemolytic streptococci were isolated. No virus studies were made.

Differential Diagnosis

This outbreak appears to be one of a contagious exanthem resembling the one described in Pennsylvania,[1] and differing in certain respects from previously named diseases. It can be distinguished from measles, rubella, roseola infantum, erythema infectiosum, the "Boston disease" and scarlet fever.

Absence of cough, conjunctivitis and Koplik's spots, and the character of the eruption make it seem unlikely that this is atypical measles.

Although the appearance of the fully developed rash is similar to that seen in German measles, its course and distribution, as well as the

shorter incubation period and the absence of occipital and posterior cervical adenopathy are distinguishing points.

Roseola infantum[2] has a longer pre-eruptive febrile period, affects primarily a younger age group, and the eruption is composed of larger and more scattered maculopapules.

In "Boston disease"[3] and erythema infectiosum,[4] the character, onset and distribution of the rash are different.

The most important disease, from a practical point of view, with which this entity may be confused is scarlet fever. In scarlet fever, however, the rash begins on the neck, next is noted on the face, and later involves the trunk, axillae and groin. The systemic reaction is usually more severe, the throat is more painful, itching is not a common complaint, the incubation period is much shorter, and complete desquamation occurs. Scarlet fever is, by definition, "an acute infection, primarily of the throat, caused by a member of the Group 'A' beta hemolytic streptococcus."[5] In the Pennsylvania outbreak and this one, no beta hemolytic streptococci were found in throat cultures on broth or blood agar. The disease therefore presumably is not scarlet fever.

While restrictions on patients with scarlet fever and their contacts have been much relaxed over those of preantibiotic days, the Florida State Board of Health still requires isolation of patients for one week or until 24 hours after initiation of effective antibiotic therapy if afebrile, terminal disinfection of premises, medical observation of contacts for one week after exposure, and more stringent precautions should the contacts chance to work on a dairy farm.[6] It therefore seems most desirable to distinguish between scarlet fever and an exanthem with a similar rash which causes a relatively mild, short illness with no known complications or sequelae.

Summary

An outbreak of a mild febrile exanthem, characterized by a bright red scarlatiniform rash beginning in the groin and affecting mostly children, especially males, occurred in Naples recently. It responded well to tetracycline treatment, which appeared to shorten the course. The socioeconomic importance of correct diagnosis is due to its resemblance to mild scarlet fever.

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Called Meeting of House of Delegates Florida Medical Association December 8

Dr. William C. Roberts, of Panama City, President of the Florida Medical Association, has called a meeting of the House of Delegates for 9 a.m., Sunday, Dec. 8, 1957, at the George Washington Hotel in Jacksonville to specifically consider Medicare. Delegates seated at the 1957 Annual Meeting of the House at Hollywood are eligible to be registered and to vote at this special session. All Association members are welcome to attend.

On Saturday preceding the meeting of the House of Delegates, there will be a meeting of Blue Shield.

Encephalitis in Cat Scratch Disease

Report of Two Cases

David R. Gair, M.D.
and
William L. Walls, M.D.
Miami

Cat scratch disease is a relatively new clinical entity; approximately 200 cases have been reported in world literature since 1951. In only 12 of these cases, however, were there associated neurologic manifestations.[1-12] It is the purpose of this paper to present two additional cases of cat scratch disease with major central nervous system manifestations.

Classically, cat scratch disease consists of regional lymphadenitis with or without formation of sterile pus and an initial skin lesion usually following a cat scratch. In the majority of cases the disease runs a short, mild course. Fever and systemic symptoms are common, but rarely is the central nervous system involved. Although an etiologic agent has not been demonstrated, the presumptive diagnosis is based on obtaining a positive reaction to a skin test with an antigen prepared from an affected lymph node.

Report of Cases

Case 1.—A 10 year old Negro boy apparently had been in perfect health until Oct. 10, 1954, the day of admission to the hospital, when he suddenly cried aloud and was found on the floor with his body rigid and his arms and head in clonic motion. This state lasted approximately 15 minutes, after which the patient became relaxed, but was stuporous and extremely irritable. He was taken to Temple University Medical Center for emergency treatment, where the only specific physical findings besides the stuporous state were enlarged epitrochlear and axillary nodes on the right side. The child was then admitted to St. Christopher's Hospital for Children.

Physical examination at the time of admission revealed a boy out of contact with reality, in a stuporous condition, and most irritable when touched. Enlarged right epitrochlear and axillary nodes were noted. There was a large perforation of the right tympanic membrane. He was afebrile, but shortly thereafter his temperature rose to 100.6 F. Respirations were 24 per minute and regular. The remainder of the physical examination was within normal limits.

The history revealed that there were many cats around the patient's home, and he distinctly remembered being scratched by a cat on the right hand a short time before the onset of his illness. Seven weeks prior to admission, the patient had a bullet wound of the terminal portion of the right index finger, for which he received penicillin and tetanus antitoxin, and the wound was sutured.

From the Department of Pediatrics of the University of Miami School of Medicine and the Pediatric Service of the Jackson Memorial Hospital, Miami, and the Department of Pediatrics of Temple University School of Medicine and the Department of Pediatrics of St. Christopher's Hospital for Children, Philadelphia.

The initial laboratory studies revealed a hemoglobin of 12.4 Gm. per hundred cubic centimeters and a white blood cell count of 20,150 cells per cubic millimeter. The spinal fluid pressure was 85 mm. of water. The fluid was clear and contained 3 cells per cubic millimeter. The protein content was 40 mg. and the sugar 50 mg. per hundred cubic centimeters. The Pandy test gave negative results. A culture of the fluid grew no organisms. Examination of the urine revealed no abnormalities. The urine was negative for coproporphyrins.

On the second hospital day, the temperature returned to normal. The patient suddenly sat up and was mentally alert. He could not remember anything that had taken place since the onset of his illness. He remained afebrile for the remainder of his hospital stay. Aqueous penicillin, 500,000 units every six hours intramuscularly, was given during the first day. The next day the patient was given Terramycin, 200 mg. every four hours, and remained on this therapy for seven days.

Studies of the cerebrospinal fluid, repeated nine days after admission, showed no significant change. A white blood cell count on the day after admission was 16,750 cells per cubic millimeter with a normal differential count. There was no basophilic stippling of the red cells, and repeated sickle cell preparations gave negative results. A VDRL was nonreactive. The results of heterophil and febrile agglutination studies were negative. The reaction to tuberculin tests was negative, and also to the Frei test. A nasopharyngeal culture grew Staphylococcus aureus, sensitive to Terramycin.

Roentgenograms of the skull showed evidence of apparently inactive right mastoidal involvement without bony breakdown. Roentgenograms of the chest and right hand revealed no abnormalities. An electroencephalogram was compatible with encephalitis. Pus aspirated from the right epitrochlear lymph node was sterile. The right epitrochlear node was excised, examined and reported pathologically as reactive hyperplasia. Endermal injection of cat scratch antigen produced at the end of 48 hours an area of induration (6 x 10 mm.) surrounded by erythema (8 x 12 mm.). Blood studies on the thirteenth hospital day revealed the hemoglobin to be 13.1 Gm. per hundred cubic centimeters, and the white blood cell count was 13,200 per hundred cubic centimeters.

The patient remained in the hospital 16 days and was apparently well at the time of discharge. He was seen slightly more than a week later in the outpatient clinic, at which time the biopsy site was healing.

Case 2.—A six year old Negro boy was admitted to the emergency room of the Jackson Memorial Hospital on Sept. 4, 1955 in an active generalized convulsion. There was no previous history of convulsions. The child had had a swelling in the right axilla for the preceding week, and this mass had become increasingly larger and more tender. There was no history of fever. On awakening the morning of admission, the boy complained of being unable to move the right arm because of the exquisite tenderness of the right axillary mass. His mother noted a short tremor of both upper extremities at that time. Approximately two hours later, the patient had a generalized convulsion and was brought to the hospital. Significant past history was that he had been in this hospital for infectious hepatitis in January 1954.

Physical examination revealed a well developed, well nourished Negro boy in a generalized convulsion. Respirations were 24, the pulse rate 124, and the temperature

99.8 F. rectally. The eyes were rolled upward, fixed and staring. The seizure ceased after he received 128 mg. of Nembutal by suppository and 64 mg. of Sodium Amytal intravenously.

The pupils were dilated, but reacted slowly to light. There was no nystagmus. The fundi were clear with no papilledema. There were small shotty cervical nodes bilaterally. In the right axilla there was a 2 by 3½ by 4 cm. moderately firm mass. Neurologically, the deep tendon reflexes were absent. The Babinski sign was present bilaterally. The Kernig and Brudzinski signs were absent. The patient was incontinent of urine.

The laboratory work on admission was as follows: red blood cells 3,740,000, hemoglobin 10.0 Gm., white blood cells 23,600; differential count 27 stab forms, 60 neutrophils, 11 lymphocytes, 1 monocyte and 1 eosinophil; platelet count normal; spinal fluid, 6 mononuclear cells per cubic millimeter, protein 46 mg. per hundred cubic centimeters, sugar 109 mg. per hundred cubic centimeters; blood sugar 141 mg. per hundred cubic centimeters; urine negative; sickle cell preparation negative.

The patient was somewhat improved eight hours after admission to the hospital and was able to take soup and milk. Shortly thereafter, however, he had another generalized convulsion and remained semicomatose and unresponsive for the next three days. During this period of coma, he had frequent localized convulsive movements of the right and left sides independently, involving the arms, legs and face. Barbiturates and Avertin were used intermittently to control the seizures; no further seizures were noted after the third hospital day. A stomach tube was passed on the fourth hospital day, and fluids and medications were given thereby. Dilantin and later phenobarbital were given prophylactically over the patient's remaining hospital stay.

Antibiotic therapy was started on admission to the hospital because of the possibility of a brain abscess, and included penicillin, tetracycline and erythromycin both parenterally and by mouth.

The patient began to arouse on the fourth hospital day and by the sixth day was alert enough to take food and medications by mouth. Over the next several days he began to show gradual improvement, but exhibited frequent episodes of wild behavior, with long periods of loud screaming and crying interspersed with periods of silly laughter and striking his head against the bed rails. He also had incontinence of urine and feces. His speech remained garbled for approximately ten days after awakening. On the sixteenth hospital day, the patient was speaking clearly, following commands and laughing appropriately. He was able to stand, but was unsteady on his feet, and he walked on a wide base. He had an intention tremor of the right arm, the Babinski sign was present on the right, and the finger to nose test on the right was grossly abnormal. Proprioception was intact. The intention tremor became much less pronounced over the next few days, and the gait became normal.

Aspiration of the right axillary mass, which had gradually become fluctuant and larger, was performed on the thirteenth hospital day. A thick yellow material was removed, which showed no organisms on smear or culture.

In reviewing the course in the hospital, it became apparent that cat scratch encephalitis could explain the entire picture, despite no history of the patient being scratched or bitten by a cat. Cat scratch antigen, obtained from Dr. Worth B. Daniels, was given intradermally. Within 48 hours, there was an area of induration 0.5 cm. in diameter, which increased in size to 1 cm. in the next 24 hours.

A second aspiration of the axillary node gave negative results on smear and culture. The patient was discharged 37 days after admission. The axillary mass was about gone at that time, and had completely disappeared when he was seen in the clinic one week later.

Other studies made while the patient was in the hospital were as follows: Blood culture on admission gave negative results. Lumbar punctures, repeated one and 11 days after admission, were essentially the same as on admission. White blood cell counts, four, nine and 26 days after admission, revealed a gradual return to a normal and differential count. Stools were negative for ova or parasites. The P.P.D. No 1 test for tuberculosis gave negative results. Electroencephalograms made nine and 25 days after admission were both grossly abnormal, and consistent with acute inflammation of the brain.

Comments

We were particularly impressed by the suddenness and violence of the onset of central nervous system symptoms in the cases reported, by the severity and duration of the neurologic manifestations, especially in case 2, and by the apparent full recovery from the disease in both instances. Both of the patients were apparently well until the day of admission. In each instance, the diagnosis was suspected during the acute or subacute phase of the illness, and appropriate skin tests were performed.

It is our opinion that in any case of regional lymphadenitis associated with a sudden onset of convulsions in previously well children with normal or equivocal spinal fluid findings, the diagnosis of cat scratch disease should be entertained.

Although these clinical findings and the presence of a positive reaction to skin tests with the available antigens are not proof of any etiologic agent, the association is probably significant.

Summary

Two cases of cat scratch disease with nervous system involvement are reported. In both instances, the patients were children; one was the youngest patient whose case has been reported in this country. In both cases, the diagnosis was made on the basis of clinical and laboratory findings and a skin test with specific antigen. Each patient apparently made a full recovery.

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ABSTRACTS

Wounds of the Colon and Rectum (1,222 Casualties). By C. Frank Chunn, M. D., and Richard V. Hauver, M. D. In Surgery in World War II. Volume II. General Surgery. Editor in Chief, Colonel John Boyd Coates, Jr., MC; Editor for General Surgery, Michael E. DeBakey, M. D. Washington, D. C., Office of the Surgeon General, Department of the Army, 1955, pp. 255-274.

This detailed analysis of a series of 1,222 casualties with wounds of the colon or rectum, or both, treated by surgical teams of the Second Auxiliary Surgical Group between Jan. 1, 1944, and May 8, 1945, is Chapter XX of General Surgery, Volume II, one of the recently issued volumes of the history of the Medical Department of the United States Army in World War II. It is a part of the brilliant record of extremely urgent surgery performed in forward Army medical units during that war.

In this series, the age range was 25 to 40 years. The injuries consisted entirely of perforations, transections, and other severe injuries to the large bowel, including injuries which resulted in interruption of the blood supply. The average lapsed time from wounding to operation was 10.9 hours, the interval being essentially the same for both fatal and nonfatal cases. While the case fatality rate rose progressively from 19.5 per cent in univisceral injuries to 100 per cent when five additional organs were injured, there was no consistent increase in the rate for the various time intervals after injury. The case fatality rate increased proportionately with the increase in the degree of shock; the degree of shock was also related to the number of organs injured. In the immediate resuscitation and preparation for operation of patients with wounds of the colon, the greatest reliance was placed upon blood, which was used immediately, liberally, and always in larger amounts than plasma. As experience increased, operation was performed earlier in the period of resuscitation and active shock therapy was continued throughout the operative procedure.

In general, all surgical procedures involved three basic technics: exteriorization of the wounded segment of bowel, diversion of the fecal stream away from wounds of the distal or lower colon and rectum, and incomplete diversion of the fecal stream. The special procedures carried out are described, as are the particular problems presented by the various regional injuries. The 433 deaths in forward hospitals among the 1,222 patients represented a case fatality rate of 35.4 per cent. Shock, which occurred in 185 cases, 46.6 per cent of the fatalities in which the cause of death could be determined, was the largest single primary cause of death.

Allergenicity of Tranquilizing Drugs. By Clarence Bernstein, M.D., and Solomon D. Klotz, M.D. J. A. M. A. 163:930-933 (March 16) 1957.

The large number of so-called tranquilizing or ataraxic drugs now at the physician's disposal have produced reactions that are thought to be due to allergic sensitization. Meprobamate, an effective tranquilizer with low toxicity and a wide range of usefulness, has given rise to allergic reactions in eight patients observed by the authors and in seven other patients reported to the authors by personal communication. The reactions included urticaria, elevation of temperature to 40 C, arthralgia, purpura, and, in a woman being treated for lupus erythematosus, a flurry of new skin lesions. Several of the patients with these reactions had previously used mephenesin; physicians might ponder the possibility that mephenesin may presensitize patients to meprobamate, though this has not been established beyond speculation. Reserpine and chlorpromazine have also caused side effects essentially different and more variable in type. Percentage-wise, the incidence of allergic reactions to the tranquilizing drugs has been extremely low, but the hazard must be kept in mind because some of the symptoms, especially the fever, may confuse the picture during the course of a usual, well understood clinical entity or syndrome. Contact dermatitis in physicians and nurses who prepare and use ampule solutions must be suspected.

To Socialized Medicine and Socialism by Way of the Veterans Administration. By Louis M. Orr, M.D. J. A. M. A. 162:860-865 (Oct. 27) 1956.

"We, and I mean all of the American people," says Dr. Orr, "must decide soon, before it is too late, what is to be the future course of the VA hospital and medical care program. That decision will determine whether we protect and improve our private system of health care for all

people or whether we eventually reach socialized medicine by default." In this strong appeal, he points out that the medical program of the Veterans Administration shows a steady development from 1917, when the first purely medical benefits for veterans were authorized and limited to veterans with service-connected disabilities, to 1956, when the 170 VA hospitals have more than 123,000 constructed beds and more than 114,000 operating beds as compared with 37,570 patients with service-connected conditions and almost 66,000 with non-service-connected conditions. The course of this wasteful development must lead either to an inequitable situation in which one third of the adult citizens are, while two thirds are not, entitled to free hospitalization, or else to government hospital and medical care for the entire population. The unfair discrimination that now operates could be obviated by developing the present plan consistently to its abhorrent conclusion, namely, complete government control over all personnel and services, with tax-paid, politically controlled medicine for everybody. The reasonable alternative is to reverse this trend as regards the VA program and to protect and improve the private system of health care for all people.

The Value of Entozyme® in the Clinical Management of Diabetes Mellitus. By B. E. Lowenstein, M.D. Am. Pract. & Digest Treat. 7:1465-1468 (Sept.) 1956.

Clinically, the author has noted that some diabetic patients, particularly those who seem to need protein most, fail to derive the anticipated benefits from a high protein diet. It seemed to him likely that the failure of such patients to improve might be ascribable to a partial failure of their digestive apparatus. For this reason he decided to study the effect of adding to the high protein diet tablets containing the pancreatic digestive enzymes, in order to insure that the food eaten was properly digested. The results thus far obtained have been sufficiently encouraging to warrant the publication of a preliminary report.

Significant symptomatic improvement was shown by a group of 25 diabetic patients treated with a high protein diet, oral pancreatic enzymes (Entozyme) and careful control of their insulin dosage so that neither excessive hyperglycemia nor hypoglycemia occurred. There was also in most cases not only a decline in the serum cholesterol levels but a reduction of insulin requirements. It is suggested that this improvement was due to redressing the nitrogen balance and making available the lipotropic activity of protein, as well as other intrinsic factors which are essential to normal tissue metabolism.

Effects of Prolonged Stilbestrol Therapy on Hematopoiesis in the Pregnant Human. By Sidney J. Peck, M.D. Obst. & Gynec. 5:796-800 (June) 1955.

In this study, the hematopoietic response of 10 normal pregnant women to large, prolonged doses of stilbestrol (Smith regimen) is reported. This regimen, begun in the early weeks of gestation, called for an increasing dosage schedule up to the thirty-sixth week of gestation. There were 2 primigravidas and 8 multigravidas in the study. Their average age was 25.2 years, with the range from 19 to 32 years. The results showed no significant alteration in the mean erythrocyte count, hematocrit, or hemoglobin values. The mean iron-binding capacity was elevated above normal levels at the height of stilbestrol therapy and after the withdrawal of the hormone (antepartum, 38 weeks). The mean serum-iron values showed a decrease at the height of stilbestrol therapy. The mean erythrocyte protoporphyrin values were elevated to anemia levels ante partum, both at the height of therapy and after the withdrawal of stilbestrol (38 weeks). The alterations in serum iron, iron-binding capacity and erythrocyte protoporphyrin were noted earlier in pregnancy than in untreated pregnant women. In five stilbestrol-treated patients anemia developed. No significant changes were noted in the mean hemoglobin mass, cell volume, or reticulocyte or leukocyte numbers.

It is concluded that stilbestrol administered during pregnancy may be an additional factor in the production of pregnancy anemia.

Pulmonary Resection for Tuberculosis. By James D. Murphy, M.D., and James M. Davis, M.D. J. Thoracic Surg. 32:772-777 (Dec.) 1956.

The high morbidity and mortality rates associated with excisional therapy for pulmonary tuberculosis resulted in virtual abandonment of that means of treatment prior to 1943, followed by its revival at the beginning of the chemotherapeutic era. The authors, along with others, were impressed by the favorable early results obtained when the lesions of pulmonary tuberculosis were resected under the protection of streptomycin. It was the consensus, however, that proper evaluation of this means of therapy could not be made

until the patients had been followed for five to 10 years. The authors here present a study on 148 patients who underwent 150 pulmonary resections during the years from 1946 to 1950. In the series, 83 pneumonectomies were performed and 67 lobectomies or resections of smaller units than a lobe.

The operative mortality was 2.7 per cent and the total mortality was 17.3 per cent. In the study there was 100 per cent follow-up. Seventy-two per cent of the entire group and 82 per cent of the patients who left the hospital alive obtained satisfactory results. Negroes often required a more extensive resection than white patients, but did as well or better in so far as mortality, morbidity, and long term follow-up were concerned.

Radiographic Findings in Certain Diseases Peculiar to a Subtropical Climate. By Gerard Raap, M.D. South. M. J. 50:189-194 (Feb.) 1957.

Dr. Raap reviews a few uncommon diseases which may occasionally be encountered in the South, either as importations or as examples of indigenous disease. In this interesting account he presents observations and experiences with malaria, amebiasis, ainhum, leprosy, echinococcus cyst, mango bezoar, ascariasis, screwworm infestation, and schistosomiasis.

Cystic Medial Necrosis as a Cause of Localized Aortic Aneurysms Amenable to Surgical Treatment. By Henry T. Bahnson, M.D., and Arthur R. Nelson, M.D. Ann. Surg. 144:519-528 (Oct.) 1956.

The authors recount recent experiences with five cases of cystic medionecrosis of the aorta treated surgically. In summary, they observe: Cystic medionecrosis may be the cause of a localized aortic aneurysm. Such aneurysms have been seen principally in middle-aged patients in the ascending aorta but also at the distal end of the aortic arch. In the latter location the lesion may be treated by excision and aortic anastomosis, possibly with an interposed graft. When the ascending aorta is involved, the aortic valve may become incompetent as a result of dilatation of the valve ring. The aneurysm as well as the valvular incompetence has been relieved by excision of part of the circumference of the aorta and restoration of an essentially normal diameter. The structurally weakened aortic wall was reinforced with a nylon binder. The condition can be recognized clinically and should be treated before great dilatation of the aorta, aortic dissection, or chronic heart failure occurs.

Cystic medionecrosis is a poorly understood cause of aortic disease. Results of surgical treatment as well as the underlying disease require further investigation.

Senile and Seborrheic Keratoses: Localization of Succinic Dehydrogenase, Protein-Bound Sulfhydryl and Disulfide Groups. By Alvan G. Foraker, M.D., and William J. Wingo, Ph.D. Am. J. Path. 32:521-533 (May-June) 1956.

The effects of aging in the skin are obvious, psychologically important, and accessible to study, but comparatively little is known of their pathogenesis, prevention, or retardation. As a contribution to knowledge of the aging process in the skin, a study was made of the occurrence and distribution of dehydrogenase activity and of protein-bound sulfhydryl and disulfide groups in senile keratoses and seborrheic keratoses. The results were as follows: (1) Dehydrogenase activity and sulfhydryl groups, both related to vital phases of cell function and growth, were found in non-keratinized cells of both lesions, as well as in basal and malpighian layers of adjacent epidermis. (2) Evidence of dehydrogenase activity diminished in cells undergoing keratinization and was absent in regions of complete keratinization. (3) Disulfide groups, related to cell keratinization, and sulfhydryl groups were found in keratinizing cells and in regions of keratinization in senile keratoses, seborrheic keratoses, and in epidermis.

Despite the more ominous precancerous potential of senile keratoses, with these technics their histochemical reaction pattern was essentially similar to that found in seborrheic keratoses.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

VOLUME XLIV
NUMBER 5

President's Page

The Old Army Game

No! It isn't stud poker. It's the application of the old military lingo: "Hurry up and wait," or, as was the slogan in battle: "Use it up. Wear it out. Temporize. Make it work." That is the attitude and that is the challenge we are confronted with today.

The "hurry up and wait" attitude was brought to mind this night after the obstetric supervisor called me to the hospital because my patient was about to deliver, in her opinion, and I should hurry. You who practice obstetrics know what I mean. It's no reflection on the ability of a well trained nurse, but here I am after two hours and no delivery imminent. There is nothing wrong, but the attitude of "hurry up and wait" is very real, yet, very proper and scientific.

This also brings to mind that we are in the act of attempting to carry out "Operations Medicare," which from the beginning up to now is a "hurry up and wait" affair. The government actually forced us to hurry up with the negotiations of the contract in the beginning, and then promised to renegotiate seven months later. Before this time approached, the government announced its intention to delay renegotiation for an extended period. Now we hope this will take place in January 1958.

In the meantime, our Association, by resolution, has altered the original agreement with the government. This resolution also carried with it a mandate that the Board of Governors devise ways and means of taking care of the dependents involved until another contract is negotiated. This resolution stated that the cost to the taxpayer would be less than with the original fixed fee schedule. This portion of the resolution further brought to mind the battle slogan: "Use it up. Wear it out. Temporize. Make it work." In carrying out the mandate of the resolution the members of your Board of Governors have done the best they could under the circumstances. They are using the old contract as much as possible. They hope to wear it out. They have temporized as much as they could. They hope to make Medicare work.

We have up to now enough experience, opinions, problems, good and bad, to know we have a real challenge before us if we continue to carry on Operations Medicare in Florida to the satisfaction of all concerned. Right now ours is a divided camp in many respects. The problem is going to demand a lot of thinking, reasoning, consideration, effort, concessions oftentimes, and, if we are not careful, expense to our Association in order to reconcile this situation and come up with the best package for all. It seems inescapable that we have a special meeting of the House of Delegates to resolve this problem. This meeting is scheduled for December 8 in Jacksonville, well before the scheduled renegotiations in January. Let us come together thoughtfully. Instruct your delegates, and better yet, accompany them to the meeting. Let's deliberate with the determination to settle this problem once and for all in a manner fair and factual.

Doctors, the decision is yours. Make sure your decision is wise, workable and satisfying to the majority of the membership of our Association. Let's get away from the old army game.



THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. Box 2411 Jacksonville, Florida

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Psychiatric Analysis

As physicians continue to probe the tough tegument which separates the minutiae of knowledge called facts from the great core of the unknown, they should derive satisfaction and courage for further investigation from the ingeniousness of their methods. The human brain, because of its inaccessibility, has long resisted scientific study of its functions. The search for a cure of its ills, perforce, was of a philosophic rather than a scientific nature.

Whether the recent increase in mental illnesses is apparent because of better diagnoses, or real because the exigencies of modern day living have placed an undue burden on the psyche, does not vitiate the fact that the last decade has produced a greater interest in mental disease than at any time since Freud. Classification of mental disorders is improving. The tautology of psychiatric terminology, if not decreasing, certainly has not increased. The schizoid behavior of Freudian versus non-Freudian disciples has improved to socially acceptable levels. In fact, psychiatry recently has acquired the same affect as dermatology or opthalmology. True, the overworked psychiatrist, in trying to mete out the most good to the most patients, may have pressed the contact switch on his ECT machine too readily, or may have deprived future diabetics of some of their insulin supplies. Some psychiatrists in their zeal have perhaps carried conflicts back to the blastocyst stage of embryonic development, but these men, as they dispensed their therapies, were also accumulating knowledge and trying to discern what was true and useful knowledge, so that the excessive swings in their enthusiasm for one type of treatment over another must not be too hastily condemned.

In any phase of medicine the impact of a new therapeutic agent often has a greater effect on the physician than on the patient receiving the drug. The introduction of chlorpromazine to psychiatric therapy was more stimulating to mental disease researchers than a self-administered electroshock. Unfortunately, psychiatrists have yet to face the hangover which the sobering glare of retrospect will have on the present day debauch of tranquilizers, stimulants, calmatives and energizers which chlorpromazine introduced in its

wake. In this therapeutic morass, a clear path has become visible leading to a further study of physicochemical dysfunctions and imbalances as a cause of mental illnesses. The demonstration that a schizophrenic-like state may be produced by a chemical agent assures further progress in this direction.

Medicine, like the lives it tries to protect and prolong, is dynamic. It is only by constant striving along empiric lines that the physician is able to glean some knowledge of man and his ills. What is accepted as law and fact today may be disproved tomorrow. Were the basis of modern day psychiatry proved entirely false tomorrow and all mental illnesses shown to be due to physicochemical causes, no psychiatrist need bow his head before his peer in apology for present day treatment. The very fact that psychiatrists have been able to diagnose, classify and develop satisfactory methods of treatment for many mental illnesses is indeed a gigantic feat considering that by the very nature of the brain, methods of a scientific study used by other disciplines of medicine were precluded. If the teachings of Freud, Adler, Jung and others were totally discarded as false, the magnificent intellects of these investigators would assure that some day the ills of man's psyche will yet be cured by the minds of men similar to theirs. Though their theories may be proved wrong in part or in toto, their energy, their methods, their analyses, and the integration of the nebulous functions of the mind and its ills will endure forever as a tribute to their minds and the mind of man.

Artery Bank Problems

The cooperation of the medical profession and the lay public of Florida is urgently needed in an endeavor vital to the saving of lives in selected cases, namely, that of the procuring of arteries for artery banks. Such cooperation has not been forthcoming in certain areas so that efforts toward forming a bank in one city have been abandoned. At least two cities that have banks have encountered difficulties in obtaining grafts because of lack of wholehearted cooperation by members of the medical profession, particularly some of those in key positions, and lack of knowledge on the part of the public as to the importance of these vessels.

Articles in the current issue of The Journal of the Florida Medical Association as well as numerous articles in current medical literature should indicate to the profession that cardiovascular surgery represents one of the most significant advances in the medical as well as the surgical treatment of many diseases heretofore thought hopeless in so far as rehabilitation is concerned.

The fact that Florida surgeons are attempting to keep abreast of the times should be appreciated by the profession as well as the public. Efforts should be made to stimulate interest in the securing of materials with which this work can be done. A handful of surgeons and a few pathologists cannot be expected to do it alone.

The cooperation of the public as well as public officials can be obtained if we properly advise and educate them. Properly worded autopsy permits will permit cooperative pathologists and others to secure these vessels. The placing of a few catheters in the remaining ends of certain vessels will overcome the objections of the morticians. Once they understand the importance of our need, they are cooperative as long as they are not impeded in performing their tasks.

The medical profession in some localities outside our state have utilized the press and other public mediums in bringing the facts to the people. They pointed out that sudden death may not mean the end of earthly contributions by loved ones. Living memorials can be established by permitting the use of their arteries for someone who otherwise may not survive. Obtaining the arteries causes no more disfigurement to a body than a sutured operative wound or an ordinary postmortem examination.

Three artery banks are operating in Florida, in Jacksonville, Miami and Orlando. Their activities need not be limited to their immediate locality. The full capacity of these banks is not realized because of lack of blood vessels. Certainly our highways and other danger spots produce enough deaths in young, healthy people to more than supply our demands. Let us utilize

our facilities for the advantage of that unfortunate patient who may need replacement of a vessel. If laws and public servants are all that stand in our way, let us bring our laws up to date and let us educate our public servants, or see that educated ones replace them. Other progressive areas are not hamstrung by the opposition of a few and the apathy of many.

Annual Meeting—Scientific Program

The scientific program of the annual meeting of the Florida Medical Association presents an unequaled opportunity for Florida doctors to present their work to the profession. The practicing physicians in the state have opportunities to record observations on health problems which could not be made in other parts of the country. Because of its rapid growth, Florida is becoming more and more a "melting pot" with its people moving here from various parts of the land. The effects of the change in climate, of different types of work and of dislocation from a familiar setting produce problems. Our geographic situation with the large number of fresh water lakes, as well as two bodies of open salt water, and the direct angle of the sun's rays, as well as the geologic formations which govern our natural resources of minerals and water, offer interesting fields for study. Certain of the more exotic diseases may be recognized more frequently here than elsewhere in the nation, and common diseases often present a somewhat different natural history than that seen in metropolitan areas. Reports of observations of this type have been given to the Association in the past.

The program for the next scientific session, to be held May 10-14, 1958, at Bal Harbour, Miami Beach, will be selected by the Committee on Scientific Work on November 16. The heart of a scientific meeting is the caliber of the original papers presented. A place can still be found on the program for presentation of good work.

The development of new industries in the state with health problems not previously faced by our physicians offers a fertile field for observations. A growing problem is the increase in accidents of all types and the need for development of preventive measures. Treatment centers for cases of poisoning have been established in many hospitals as the result of presentations on this subject to the Association. Automobile accidents are increasing, and the fearful toll on our roads should be critically examined for means to reduce it. The great distances in Florida, the straight roads, and the pressure to meet vacation schedules lead to conditions which invite tragedy. The alteration in the character of agriculture in the state is changing the type of farm accidents. The great opportunities for recreation with our intense sun, the phenomenal increase in outboard motor boating and water skiing must be changing the types of injuries seen by our physicians. The increase in problems associated with aging has long been recognized because of the steady migration of senior citizens into the state over many years. The effects of the change of food, water and economic status on their nutrition could well be studied.

The scientific exhibits present an opportunity not only for presentation of original research and new technics, but for review in perspective of knowledge that has been accumulating over a period of years. The exhibits also serve for unusual presentations of historical, broad general scientific, or cultural nature related to medicine. An excellent example of this type of exhibit received much attention at the 1957 meeting.

The caliber of scientific motion pictures prepared by Florida physicians has been unusually high and the reception by the profession exceedingly gratifying. The physical facilities for the showing of motion pictures will be improved at the next meeting.

The Committee on Scientific Work will review abstracts of papers, exhibits, and motion pictures proposed by members of the Association, select those which seem of greatest interest, and arrange them into a cohesive program. The innovation last year of a day predominately devoted to scientific papers permits busy practitioners to condense the maximum up-to-the-minute postgraduate education into a single day.

It is not too early for members to begin now to plan presentations for the program in 1959. If

data are carefully collected and observations made during the present busy fall and winter season, they can be organized and analyzed in the spring and summer. A review of the literature will permit conclusions to be reached in ample time for submission of abstracts in the fall of 1958. The preparation of scientific material for presentation to professional colleagues is a stimulating intellectual experience, a rewarding type of self education, and a duty to the profession.

"Fill Our Hearts With Thankfulness"

Traditionally, November is the month in which the American people count their blessings nationally. Thanksgiving Day is set aside for the formal observance of a day of thanks for all the benefits and privileges, the innumerable fruits of achievement through the years, which have accrued to the citizenry of this great democracy since its founding. Pulpit and press and patriotic organizations extol the founding fathers and the glories of the democratic way of life. Such a celebration is an altogether fitting tribute to a great heritage. Should it not be even more?

Thanksgiving is an appropriate time for every citizen to take stock of his individual worthiness to share in this heritage and to evaluate his personal contribution toward keeping his country strong and great and destined for an ever greater future. A free country thrives only at a price. The recipients of its bounty must in turn make their contributions toward keeping their country free and great.

The spirit that will insure the glory of America in the full strength of its greatness is exemplified by the epitaph on a simple shaft that marks the burial place of one of the immortals among the founding fathers. Two days before his death, Thomas Jefferson wrote this epitaph with his own hand:

"HERE WAS BURIED
THOMAS JEFFERSON,
AUTHOR OF THE
DECLARATION OF
AMERICAN INDEPENDENCE,
OF THE STATUTE OF
VIRGINIA FOR
RELIGIOUS FREEDOM
AND FATHER OF
THE UNIVERSITY OF VIRGINIA."

True enough, Jefferson was Governor of the State of Virginia. He was elected to the Congress. He was appointed Minister to France. He was chosen to be Secretary of State. He was elected Vice President. He was twice elected President of the United States by a grateful Republic. Why, then, his insistence on this extraordinary record of his life and his place in history?

Jefferson himself gave the answer. To his daughter he explained the reason why this inscription, and not one word more, was to mark his resting place. "The things that are not on my inscription," he said, "are things the people did for me. The things that are on it are things that I did for the people."

In his prayer book, Jefferson recorded this prayer for his country:

"Almighty God, who has given us this good land for our heritage; we humbly beseech Thee that we may always prove ourselves a people mindful of Thy favor and glad to do Thy will. Bless our land with honorable industry, sound learning, and pure manners.

"Save us from violence, discord and confusion; from pride and arrogance, and from every evil way. Defend our liberties, and fashion into one united people the multitudes brought hither out of many kindreds and tongues.

"Endowe with the spirit of wisdom those to whom in Thy Name we entrust the authority of government, that there may be justice and peace at home, and that through obedience to Thy law, we may show forth Thy praise among the nations of the earth.

"In time of prosperity, fill our hearts with thankfulness, and in the day of trouble, suffer not our trust in Thee to fail; all of which we ask through Jesus Christ our Lord. Amen."

At this Thanksgiving season, the citizens of this entire nation would do well to lift this prayer of Thomas Jefferson on high as their own.

Physicians' Role in Social Security Cash Disability Benefit Program

As the Federal Social Security Administration's cash disability benefit program moves into the actual payment stage, the important role of doctors in the program becomes increasingly evident.

More than 100,000 disabled persons received benefit checks during the month of August. Each had been able to qualify under this strict federal disability program only because of the voluntary cooperation of his doctor.

The individual physician enters into the picture when the claimant is requested by the Social Security Administration to submit to that agency medical evidence of his disability. (Under the law, the disability must be such as can be proved by medical evidence.) There are two major points in connection with each disability that must be considered in the adjudication of each claim:

1. What was the onset date of the disability? When did it begin?
2. What is the present condition of the claimant?

Each applicant is given medical report forms. He is required to obtain his own medical evidence by submitting the forms to one or more doctors who have examined him and who would be in a position to furnish the needed information. (The responsibility rests entirely on the applicant; the Social Security Administration is not permitted to pay for the preparation of the report forms. Whether there shall be such payment and the extent of any such fees is a personal matter between the claimant and the physician.)

The physician is not asked to determine whether his patient meets the disability requirements of the law. This is a matter decided upon by teams of professional medical and lay examiners who consider work history, education and other factors as well as the condition of the applicant.

The medical report form, prepared under the guidance of a Medical Committee, is designed to enable the physician to give sufficient information from his records for a determination to be made without repeat calls or, in the vast majority of cases, new examinations. Inherent, therefore, in the rapid, yet thorough, development of a claim for benefits is the necessity for complete information on the medical form.

In submitting this information, R. B. Donaldson, Jacksonville District Manager of the Social Security Administration, stated that, in summary, it might be said: No claim for Social Security disability benefits can be paid without adequate medical evidence of the beginning date and current status of the disability. Procurement of this evidence is a responsibility of the claimant, a responsibility which may be fulfilled only with the cooperation of his physician. Clearly, the fate of a claimant for disability benefits rests, in large part, in the hands of his doctor.

Second Medico-Legal Institute Jacksonville, November 22-23

The second Medico-Legal Institute sponsored by the Florida Medical Association and The Florida Bar is being held at the George Washington Hotel in Jacksonville, November 22-23. The first Institute was held in Miami.

The program for the Institute should be of interest to physicians from all Florida. It was made up by a committee composed of Ben J. Sheppard, M.D., LL.B., Coral Gables, Chairman, Medico-Legal Law and Procedures Committee, The Florida Bar, and W. Tracy Haverfield, M.D., Miami, a member of the Public Relations Advisory Committee of the Florida Medical Association with the special assignment of liaison with The Florida Bar, in consultation with John S. Duss, LL.B., President of the Jacksonville Bar Association; Leo M. Wachtel, M.D., President of the Duval County Medical Society, and the respective committees of the medical society and the Jacksonville Bar Association.

Registration begins at 9 a.m. Friday, November 22. Those physicians who cannot attend the first sessions may register until 5 p.m. that day.

There will be three social events: a luncheon, reception and dinner on Friday. Arrangements for attendance at these events may be made at the registration desk.

The program follows:

FRIDAY, NOVEMBER 22

9:00 a.m.—"Relationship of Cancer and Trauma"
Lucien Y. Dyrenforth, M.D., Jacksonville
Ashbel C. Williams, M.D., Jacksonville
C. C. Howell Jr., LL.B., Jacksonville

10:00 a.m.—"Relationship of Trauma and Strain on the Cardiovascular System"
Karl B. Hanson, M.D., Jacksonville
James E. Cousar III, M.D., Jacksonville
Jack F. Wayman, LL.B., Jacksonville

11:00 a.m.—"Electromyograph as an Aid in Evaluating Nerve and Muscle Injury"
Simon Markovich, M.D., Miami
Ben J. Sheppard, M.D., LL.B., Coral Gables

12:00 Luncheon

1:30 p.m.—"Crash Syndrome"
Cornell University Team

3:00 p.m.—"Whiplash"
Richard A. Worsham, M.D., Jacksonville
Walter Beckman Jr., LL.B., Miami

4:30 p.m.—"Post Concussion Syndrome"
Edward J. Sullivan Jr., M.D., Jacksonville
William H. McCullagh, M.D., Jacksonville
Roger J. Waybright, LL.B., Jacksonville

6:00 p.m.—Reception

7:00 p.m.—Dinner

SATURDAY, NOVEMBER 23

9:00 a.m.—"Back Injury, Its Cause and Sequelae"
Charles B. Mabry, M.D., Jacksonville
T. Paine Kelly Jr., LL.B., Tampa

10:00 a.m.—"Disability Evaluation"
Vernon T. Grizzard Jr., M.D., Jacksonville
George I. Raybin, M.D., Jacksonville
John E. Matthews Jr., LL.B., Jacksonville
Harry T. Gray, LL.B., Jacksonville

Southern Medical Association Meets In Miami Beach, November 11-14

The Fifty-First Annual Meeting of the Southern Medical Association opens in the auditorium on Miami Beach, November 11 and continues through November 14. Dr. Donald F. Marion, of Miami, is chairman of the Greater Miami Committees on Arrangements.

The scientific assembly will be composed of 20 sections representing the major medical and surgical specialties. In addition to the programs of the sections, many conjoint societies will offer outstanding programs.

There will be 20 guest speakers from over the nation and from foreign countries. In addition to the national television feature, "Grand Rounds," a variety of color television will be presented.

A. M. A. Clinical Meeting Philadelphia, December 3-6

The birthplace of American independence—Philadelphia—will be the scene of the American Medical Association's Eleventh Clinical Meeting, December 3-6, 1957. The center of activities will be Convention Hall where scientific exhibits, color television, motion pictures, technical exhibits and scientific lectures will be presented "under one roof." Headquarters for the House of Delegates will be the Bellevue-Stratford Hotel.

Highlights of the three and a half day convention geared especially for the nation's family doctors include: (1) A special transatlantic conference between distinguished physicians in London and Philadelphia on "Advances in Chemotherapy of Cancer" via two way telephone at 3 p.m. EST on Wednesday; (2) A complete color television schedule of surgical demonstrations emanating from Lankenau Hospital; (3) A motion picture program daily plus a special session Tuesday evening; (4) Exhibits featuring a well rounded program and special displays on the history of medicine in the Philadelphia area, fractures and manikin demonstrations on problems of delivery; (5) Panel discussions on cardiovascular disease, cancer, emotional problems of the menopause, hypertension, diabetes, arthritis, and traumatic injuries; and (6) The General Practitioner of the Year Award to be presented by the American Medical Association to an outstanding family doctor.

OTHERS ARE SAYING

This I Believe

As a doctor one sees life from its inception to its termination. In this period in my own life I have found it possible to correlate science with spiritual beliefs and the atomic age has strengthened this spiritual outlook.

Wm. Howells, a leading American anthropologist, says, "Man unlike other animals is a creature who comprehends things he cannot see and believes in things he cannot comprehend."

"Communism denies all religions and repudiates the ancient religions as 'The Opium of the People.' It is a faith proclaiming the coming triumph of man over adversity and evil, and man's eventual entrance into earthly paradise." This I cannot believe.

"Whether your religion is Hinduism, Buddhism, Islam, Judaism or Christianity your religious aspirations are similar. You seek assurance of the favor of a God, protection against the dangers of life, community with your fellows, courage in your hour of conflict, comfort in your hour of grief, guidance in your daily concerns, release from the pains of conscience and hope for some sort of immortality."

Whatever my faith or my future in this world or beyond, there is one creed I can recommend to all my fellowmen. It is: whomever I meet—whether for one minute or for a long period—I leave some good or bad and he leaves with me one or the other. When the end of life comes here on earth my physical body departs but the good and the bad remains. This I believe and I hope the good will be great and the bad so small as to be forgotten.

(Read Life's "The World's Great Religions" from which portions of the above were borrowed.)

"From Your President"
Frank J. Pyle, M.D.

Quarterly Bulletin, Orange County Medical Society, July 1957

STATE NEWS ITEMS

The Public Health Service has announced a new program of financial support for advanced training of research scientists in neurological and sensory disorders. The program will be conducted by the National Institute of Neurological Diseases and Blindness of the National Institutes of Health, Bethesda, Md.

Individual awards are subject to renewal and may be continued for a period of three years. Stipends, which may range from $5,500 to $14,800 a year, are determined individually in accordance with each applicant's qualifications and training needs.

Application forms and instructions may be obtained by writing to the Chief, Extramural Programs Branch, National Institute of Neurological Diseases and Blindness, National Institutes of Health, Bethesda 14, Md.

Drs. Clarence Bernstein and Solomon D. Klotz of Orlando and Dr. Paul J. Coughlin of Tallahassee took part on the program of the Twelfth Annual Meeting of the Southeastern Allergy Association held November 1-2 in the Fort Sumter Hotel at Charleston, S. C.

Dr. Bernstein, who is President of the Association, presided over the first scientific session. Dr. Klotz opened the discussion of the paper "Allergic Vasculitis" presented by Dr. William A. Thornhill Jr. of Charleston, W. Va. Dr. Coughlin presented a paper entitled "Vitamin and Mineral Balance."

Dr. William C. Roberts of Panama City, President of the Florida Medical Association, was among the group of physicians from Florida who attended the recent meeting of the American College of Surgeons held at Atlantic City.

Dr. Walter C. Payne Sr. of Pensacola, a former president of the Florida Medical Association, presented greetings to the Gulf Coast Clinical Society on behalf of the Association at its meeting in Biloxi, Miss., the latter part of October.

Dr. John J. Farrell of Miami will present a paper entitled "Diagnosis of Massive Gastrointestinal Bleeding" on the program of the three day Sectional Meeting of the American College of Surgeons being held in the Hotel Heidelberg at Jackson, Miss., January 16-18. Dr. Farrell will also serve as one of the collaborators on the panel for the discussion of "Complications of Abdominal Surgery."

Dr. Edward R. Woodward, formerly associate professor of surgery at the University of California at Los Angeles, has been appointed Professor of Surgery and head of the Department of Surgery at the University of Florida College of Medicine at Gainesville.

The American Psychiatric Association through support of The Smith, Kline & French Foundation is offering a number of fellowships to psychiatrists, mental hospitals, schools for the retarded and teaching institutions dedicated to public service. There are seven main types: staff psychiatrist training fellowships; awards to hospitals for teaching; extension training fellowships; student fellowships; medical fellowships; foreign scholar lectureships, and residency training fellowships. Applications should be in the hands of The Smith, Kline & French Foundation Fellowship Committee on April 15. Information is available from Dr. Kenneth E. Appel, Chairman of

the Committee, American Psychiatric Association, P. O. Box 7929, Philadelphia, Pa.

Dr. Alvin E. Murphy of Palm Beach was principal speaker at a recent meeting of the Rotary Club of Boca Raton.

Dr. Taylor W. Griffin of Quincy was among the group of Florida physicians who attended the Sectional Meeting of the International College of Surgeons held at Chicago.

Dr. Williard H. H. Bennett of Titusville was principal speaker at a recent meeting of the Kiwanis Club of that city.

Dr. William A. D. Anderson of Miami delivered the Presidential Address at the Conference of the College of American Pathologists held at New Orleans late in September. The American Society of Clinical Pathologists met jointly with the College. Following the meeting in New Orleans, Dr. Anderson went to Mexico City for a joint meeting with the Mexican Association of Pathologists.

Dr. Lauren M. Sompayrac of Jacksonville presented a film on creeping eruption at the meeting of the International Congress of Dermatology held in August at Stockholm, Sweden. He also visited clinics and hospitals while abroad.

Dr. Julian A. Rickles of Miami has returned from Washington where he attended an advanced course in atomic warfare mass casualty management at Walter Reed Hospital.

Dr. Thomas M. Palmer of Jacksonville attended the annual meeting of the Pan-American Pediatric Conference held during August in Lima, Peru. He also visited clinics and hospitals in several South American countries.

Dr. John T. Benbow of Chattahoochee has been selected as chairman of the Florida Council on Training and Research in Mental Health.

Dr. Wilson T. Sowder of Jacksonville has been reappointed State Health Officer by Governor LeRoy Collins.

Dr. Lee Sharp of Pensacola served as presiding officer of the first scientific session of the meeting of the Gulf Coast Clinical Society held October 17 in Biloxi, Miss.

Dr. Lawrence E. Geeslin of Jacksonville and Dr. Charles K. Donegan of St. Petesrburg have been appointed by Governor LeRoy Collins to the State Tuberculosis Board.

Dr. Nathan Arenson of Pensacola has been appointed chairman of the medical division for the United Fund Drive in the Pensacola area.

Dr. Joseph L. Selden of Fort Myers was one of the principal speakers on the program of the Women's Clubs held recently at Clewiston.

Dr. Rodman Shippen of Orlando discussed "Psychiatry and Religion" recently in an address before the Unitarian Fellowship of Jacksonville.

Dr. Jess V. Cohn of Hollywood presented a paper entitled "The Morbidophilic Diathesis" at the Southeastern Regional Meeting of the American College of Physicians held October 4-5 at St. Simons Island, Georgia.

Dr. Russell C. Smith of Daytona Beach discussed the increasing use of multiple intravenous fluids in anesthesia and demonstrated improved methods of dosage control at the recent meeting of the Florida Society of Anesthesiologists.

Santford Russell Wilson of the class of 1960, University of Florida College of Medicine, Gainesville, has been selected as the first recipient of the Dr. Stewart Thompson Memorial Award. This award, made available by Dr. Richard C. Cumming of Ocala, is awarded for high scholarship. It was presented Mr. Wilson at the General University Scholarship Convocation on September 23.

Dr. James C. Patterson of Tampa has returned from New Orleans where he assisted in the examination given by the American Board of Pathology at Louisiana State University School of Medicine. Dr. Patterson also attended the meetings of the American Society of Clinical Pathologists and the College of American Pathologists.

CLASSIFIED

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

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WANTED: General surgeon desires location alone or with associate. Board eligible, married, Florida license. Prefer smaller city. Write 69-238, P. O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner to join three man group in clinic practice in Miami. Florida license necessary. Adequate salary first, followed by partnership. Give details first letter. Write 69-241, P. O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner or Pediatrician to share office with M.D. in N. W. Miami. Florida license required. Excellent opportunity for young man. Write 69-246, P. O. Box 2411, Jacksonville, Fla.

WANTED: A General Practitioner, an Ophthalmologist, an Otolaryngologist to associate with group in Brevard County. Florida license necessary. Write age, training, medical experience and references. Write Box 368, Rockledge, Fla.

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FOR SALE: Fifty milligrams of radium element in five platinum needles, ten milligrams each. Price $750. Write or call W. T. Simpson, M.D., Winter Haven, Fla.

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OBSTETRICIAN - GYNECOLOGIST completing military service in March, 1958 desires coastal location with group, general practitioner or obstetrician-gynecologist. Write 69-245, P.O. Box 2411, Jacksonville, Fla.

FOR RENT: Completely equipped office lower Florida east coast. Large reception room, consultation room, two treatment rooms, laboratory, X-ray, dark room and ample parking area. Air conditioned. Write Mrs. Edwin B. Davis, 235 Phipps Plaza, Palm Beach, Fla.

COMPONENT SOCIETY NOTES

Brevard

The first fall meeting of the Brevard County Medical Society was held September 10. Members of the Woman's Auxiliary met jointly with the Society. Refreshments preceded the dinner which was attended by 59 members, wives and guests. Following dinner, the Society and Auxiliary were addressed jointly by Mr. Bruce S. Bucher and Mr. Eugene W. Boylston, of Merrill, Lynch, Pierce, Fenner and Bean, who spoke on the position of common stocks in the physician's investment program.

Broward

A film, "The Doubting Doctor," was featured at the October meeting of the Broward County Medical Association. Dr. Ernest B. Howard, Assistant Secretary of the American Medical Association, was scheduled as principal speaker on the program for the Association's November meeting.

Dade

The October meeting of the Dade County Medical Association was highlighted by a discussion of "The Physician's Role in Atomic Warfare" by Dr. Julian A. Rickles, of Miami and Dr. William M. Schiff, also of Miami. Dr. Rickles is chairman of the Association's Medical Committee for Civilian Defense.

Duval

Dr. Malcom E. Phelps, President of the American Academy of General Practice, was principal speaker for the October meeting of the Duval County Medical Society. The title of his address was "A Doctor's Duty Professionally and Otherwise."

Dr. Manson Meads, Professor of Internal Medicine at the Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C., was scheduled as principal speaker for the November meeting.

Hillsborough

Dr. Richard T. Farrior, of Tampa, was principal speaker on the program of the October meeting of the Hillsborough County Medical Association. The title of his address was "Detection and Treatment of Head and Neck Cancer."

Lake

Dr. Lorenzo L. Parks, of Jacksonville, Director of the Bureau of Special Health Services of the Florida State Board of Health, was principal speaker for the September meeting of the Lake County Medical Society. Dr. Parks discussed the licensing of hospitals and the indigent hospitalization program.

Dr. Benjamin F. Perry Jr., of Leesburg, was speaker for the October meeting. The subject of his address was "Problems in Bone and Joint Surgery."

Members of the Society voted to have a joint meeting in November with the Bar Association and its Auxiliary.

Marion

Congressman A. S. Herlong, of Leesburg, discussed recent Congressional action affecting medicine at the first fall meeting of the Marion County Medical Society held the latter part of September. Also on the program with Mr. Herlong were Dr. Henry J. Babers Jr., of Gainesville, and Mr. Joe Stansell, of Jacksonville. Dr. Babers and Mr. Stansell reviewed the developments of Blue Shield.

Members of the Woman's Auxiliary to the Society were guests at the meeting which was preceded by dinner.

Polk

The Polk County Medical Association has paid 100 per cent of its state dues for 1957.

Volusia

An address by Dr. Robert E. Zellner, of Orlando, was a feature of the September meeting of the Volusia County Medical Society. Dr. Zellner discussed Blue Shield.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. John J. Fisher, of Jacksonville, announce the birth of a daughter, Sara Ann, on August 24, 1957.

Dr. and Mrs. Floyd L. Pichler, of Jacksonville, announce the birth of a son, Daniel Lester, on August 8, 1957.

Marriages

Dr. Wm. E. Van Landingham, of West Palm Beach, and Miss Florence E. Grois, also of West Palm Beach, were married in Atlanta, Ga., early in September.

Deaths — Members

McEwan, John S., Orlando — September 26, 1957

Deaths — Other Doctors

Wallace, Albert W., Tulsa, Okla. — December 25, 1956
Bubis, Jacob Louis, Miami Beach — July 23, 1957
Edmundson, Susan O., Clearwater — July 15, 1957

Announcing The Twenty-First Annual Meeting
of
THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY
Conference Headquarters — Roosevelt Hotel
March 3, 4, 5, 6, 1958

GUEST SPEAKERS

Carleton B. Chapman, M.D., Dallas, Tex.
Cardiology
Herbert Rattner, M.D., Chicago, Ill.
Dermatology
Charles A. Flood, M.D., New York, N. Y.
Gastroenterology
Robert A. Davison, M.D., Memphis, Tenn.
General Practice
Lawrence M. Randall, M.D., Rochester, Minn.
Gynecology
Bayard T. Horton, M.D., Rochester, Minn.
Internal Medicine
Perrin H. Long, M.D., Brooklyn, N. Y.
Internal Medicine
George N. Raines, Capt., MC, USN, Washington, D. C.
Neuropsychiatry
Robert H. Barter, M.D., Washington, D. C.
Obstetrics
Ralph O. Rychener, M.D., Memphis, Tenn.
Ophthalmology
C. Leslie Mitchell, M.D., Detroit, Mich.
Orthopedic Surgery
Frank D. Lathrop, M.D., Boston, Mass.
Otolaryngology
Arthur H. Wells, M.D., Duluth, Minn.
Pathology
James Marvin Baty, M.D., Boston, Mass.
Pediatrics
Harold O. Peterson, M.D., Minneapolis, Minn.
Radiology
Jere W. Lord, Jr., M.D., New York, N. Y.
Surgery
Claude E. Welch, M.D., Boston, Mass.
Surgery
Ormond S. Culp, M.D., Rochester, Minn.
Urology

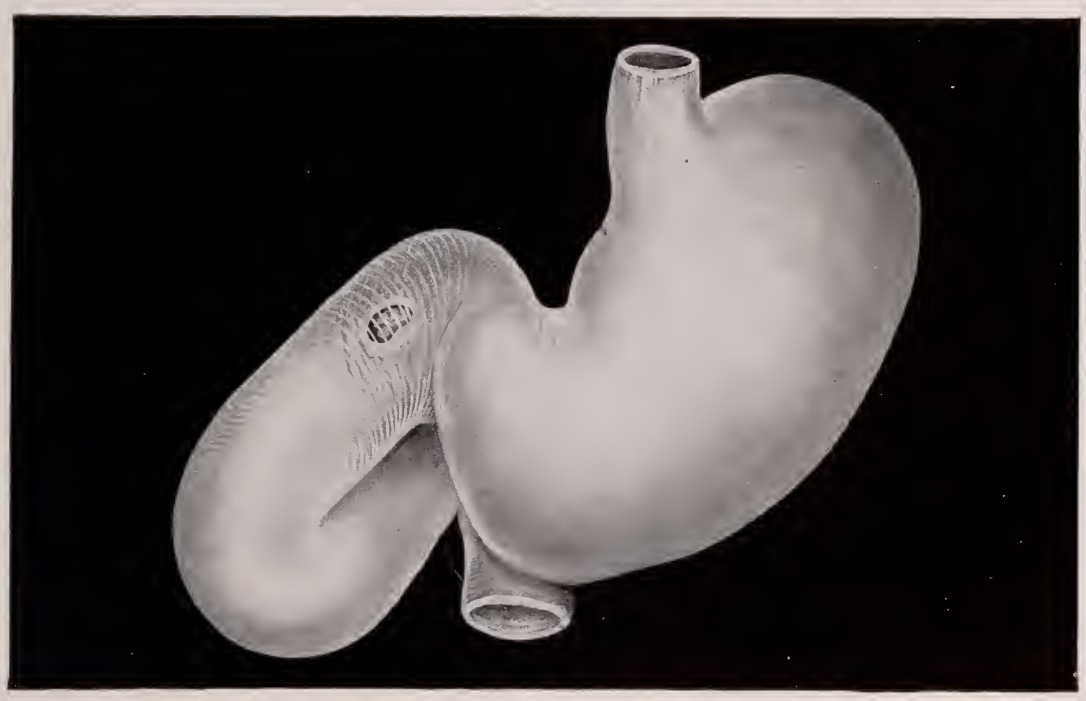
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(All-inclusive registration fee — $20.00)

THE POSTCLINICAL TOUR TO MEXICO CITY, CUERNAVACA, TAXCO AND ACAPULCO

Leaving March 7 from New Orleans and returning March 18, 1958

For information concerning the Assembly meeting and the tour write, Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

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*in depressing gastric secretory volume and in inhibiting gastrointestinal motility."**

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*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthīne in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 Cases, Am. J. M. Sc. *232*:156 (Aug.) 1956.

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Announces
SIX DAYS
of
CARDIOLOGY
(January 13-18, 1958)

Major Problems of Heart Disease will be discussed by Members of the Emory University Faculty and the following visitors:

A. Carlton Ernstene, M.D., Chairman, Division of Medicine, Cleveland Clinic, Cleveland, Ohio
Dwight E. Harken, M.D. Assistant Clinical Professor of Surgery, Harvard Medical School; Surgeon, Peter Bent Brigham Hospital; Chief of Department of Thoracic Surgery, Mount Auburn and Malden Hospitals, Boston, Mass.
Helen B. Taussig, M.D., Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine; Director of the Children's Heart Clinic of the Harriet Lane Home, The Johns Hopkins Hospital, Baltimore, Md.
Eugene A. Stead, M.D., Professor and Chairman, Department of Medicine, Duke University School of Medicine, Durham, N. C.
Ancel B. Keys, M.D., Professor of Medicine, University of Minnesota; Director of the Laboratory of Physiological Hygiene, University of Minnesota School of Public Health, Minneapolis, Minn.
Edward S. Orgain, M.D., Professor of Medicine, Duke University School of Medicine; Director, Cardiovascular Disease Service, Duke Hospital, Durham, N. C.
E. Grey Dimond, M.D., Professor and Chairman of the Department of Medicine; Director of the Cardiovascular Laboratory, University of Kansas Medical Center, Kansas City, Kansas.
Gene H. Stallerman, M.D., Associate Professor of Medicine, Northwestern University, Chicago, Ill.

Tuition fee: $100.00
Write: Postgraduate Teaching Program, Emory University School of Medicine, 69 Butler Street, Atlanta 3, Georgia



NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Akes, Charles D., Boynton Beach
Astler, Vernon B., Hollywood
Bryan, Frank M., Fort Myers
Dell, George A., Gainesville
Eichert, Arnold H., Hollywood
Eyster, William H. Jr., Indialantic
Johnson, Reginald H. Jr., Fort Myers
Jowett, John C., Orlando
Latty, Samuel G., Winter Park
Norris, Franklin G., Orlando
Olson, Edgar L., Winter Park
Tomlinson, John L., Fort Lauderdale
Wilcoxon, George M., Fort Lauderdale

Medical Licenses Granted

Dr. Homer L. Pearson Jr., Secretary of the State Board of Medical Examiners, has reported that of the 420 applicants who took the examination of the Board, held June 24 and 25, 1957, in Miami Beach, 300 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 300 successful applicants follow:

Abel, Marling Leo, Coronado, Calif. (Ohio U. 1954)
Aidem, Howard Philip, Miami (U. Illinois 1956)
Ajac, Ian Kalman, Brooklyn (Bowman Gray 1957)
Alexander, Bronson Raye, Hanover, N. H. (U. Okla. 1954)
Alexander, Stephen John Jr., Crawfordsville, Ind. (U. Cinn. 1941)
Allen, Norma Royse, St. Petersburg (Woman's Med. Pa. 1956)
Allison, Joseph, Mount Vernon, N. Y. (N. Y. U. 1947)
Ammons, John Carl, Jacksonville (Emory 1957)
Anderson, Robert Milton, Winter Haven (Tulane 1957)
Arnall, Robert Esric, Griffin, Ga. (Emory 1957)
Artzibushev, Constantin, Jacksonville (Leopold Francens U. 1950)

Babcock, Kenneth Belknap, St. Petersburg (U. Mich. 1956)
Bates, James Sewell Jr., Atlanta, Ga. (Ala. 1952)
Bauer, Robert Edward, Baltimore (U. Md. 1946)
Bell, Lewis Barclay, Chicago (Northwestern 1946)
Benet, Armando Fernandez, Tampa (U. Havana 1946)
Bennett, Joseph Jacob, Hollywood (U. Ga. 1932)
Benway, Robert Emphy, Miami (U. Miami 1957)
Berg, Charles Frederick Jr., Coral Gables (U. Pittsburgh 1956)
Berg, Leonard, Boston (U. Tenn. 1956)
Berken, Arthur, Miami (Washington U. 1957)
Berman, Donald Abel, Washington, D. C. (Tulane 1957)
Berman, Leonard David, New Orleans (N. Y. U. 1957)
Berner, Clifford Leeland, Tallahassee (U. Louisville 1947)
Bernhard, Ernest Rubin Jr., Tampa (Southwestern 1956)
Bevilacqua, Michael, South Miami (Long Island M. C. 1933)
Bishop, Charles Sidney, Boston (Tufts 1939)

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ANTI-ALLERGIC

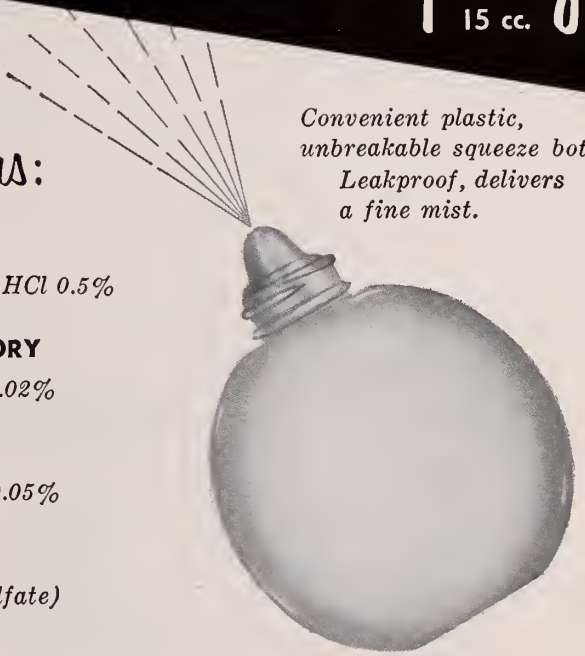
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Blanks, Marguerite, Miami (U. Miami 1957)
Blum, Lawrence Michael, Brooklyn (Duke 1955)
Blumberg, Edward, Jacksonville (U. Miami 1957)
Boulware, James Richmond III, Durham, N. C. (Harvard 1957)
Bowcock, James Zitzer, Atlanta, Ga. (Emory 1957)
Bowers, John Edward, Montclair, N. J. (Yale 1947)
Braden, Frederick Richard, New Orleans (Tulane 1952)
Brewton, Samuel Alton Jr., Thomaston, Ga. (Ga. M. C. 1956)
Brickler, Alexander Dumas, (Col.) Longbranch, N. J. (Meharry 1953)
Brinson, John Bradford Jr., Monticello (U. Miami 1957)
Brooks, Beach Alexander, Chattanooga, Tenn. (Temple U. 1953)
Brown, Leonard, Darby, Pa. (Hahnemann 1954)
Brown, Trave Lavell Jr., Parrish (Bowman Gray 1956)
Burford, Fred Jeff, St. Petersburg (Emory 1956)
Burnam, Robert Rodes, Louisville, Ky. (U. Louisville 1951)
Bush, Charles William Jr., Raiford (Boston U. 1936)

Cahoon, Stuart Newton, Miami (Temple 1943)
Campbell, Alan Brooks Jr., St. Petersburg (U. Tenn. 1955)
Campbell, William Rogers, (Col.) Miami (Meharry 1957)
Cannon, Stanley Joel, Coral Gables (Duke 1957)
Cardinale, Anthony Joseph, San Antonio, Tex. (Long Island M. C. 1923)
Carnahan, Lloyd Gerald, Rochelle, Ill. (U. Illinois 1954)
Carratt, James Angelo, Starke (Vanderbilt 1957)
Catanzaro, Santino Joseph, Mount Vernon, N. Y. (Jefferson 1936)
Chakmakis, Apostolos George, Miami (Boston P & S 1948)
Chiat, Harold, New York (Harvard 1952)
Chriss, George Samuel, Jacksonville (Marquette 1957)
Cohen, Matthew, Minneapolis, (Tulane 1957)
Cole, Sanford Howard, Newark, N. J. (Chicago 1957)
Connor, James Davis, Miami (South Carolina 1953)
Cooke, Stanford Bernard, No. Miami Beach (Hahnemann 1954)
Cooper, Floyd Childs III, Orlando (U. Tenn. 1957)
Cooper, Leonard Selby, Sarasota (Jefferson 1943)
Coury, Oswald Harry, Miami (Western Reserve 1953)
Cox, Don Rawlis, Miami (U. Miami 1957)
Creighton, James Burns Jr., Tampa (Duke 1957)
Crews, Frederick Ferris, Flomaton, Ala. (Ala. 1953)
Crotzer, Malcolm Columbus, Jackson, Miss. (U. Tenn. 1946)
Danielson, Harry Edward Jr., Miami (Indiana U. 1951)
DeFelice, Eugene Anthony, Miami Beach (Boston U. 1956)
DeLand, Frank Howard, Lakeland (U. Louisville 1952)
Demos, Menelaos Peter, Chicago (U. Miami 1957)
Dennis, Joel Bernard, Miami (U. Cinn. 1954)
Denser, Clarence Hugh Jr., Chattahoochee (Tulane 1948)
Denton, Peyton Steele, Coral Gables (St. Louis 1952)
Dieter, Donald Dean, Salina, Kansas (Yale 1942)
Dill, Leslie Van Dyke, Washington, D. C. (Duke 1936)
Downing, John Dent Jr., Tampa (U. Md. 1956)
Drewry, Garth Richard, Tampa (Harvard 1952)
Duncan, Thomas Anderson, Washington, D. C. (Emory 1957)
Dunham, Charles Thomas, Bartow (Marquette 1950)

Eason, John Richard, Tampa (U. Miami 1957)
Edwards, Jefferson Rathburn Jr., Charlottesville, Va. (St. Louis 1952)
Eff, Jack Simon, Jacksonville (U. Miami 1957)
Ehrenkranz, Nathaniel Joel, Miami (Yale 1949)
Elkins, John Thomas Jr., Havana (U. Miami 1957)
Ellis, Woodrow George, Jacksonville (U. Tenn. 1946)
Eyster, William Henry Jr., Melbourne Beach (U. Penn. 1943)
Ezzo, Joseph Anthony, St. Louis (St. Louis 1953)

Farrell, James Francis, Miami (N. Y. U. 1946)



for certain disorders of menstruation and pregnancy

TRULY EFFECTIVE PROGESTATIONAL THERAPY BY MOUTH

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T.M.

(norethindrone, Parke-Davis)

oral progestogen
with
unexcelled potency
and
unsurpassed efficacy

Now, with small oral doses of this new and distinctive progestogen, you can produce the clinical effects of injected progesterone. In amenorrheic women for example, "As little as 50 mg. of [NORLUTIN] administered in divided doses over a five-day period was sufficient to induce withdrawal bleeding."[1]

CASE SUMMARY[2]

Amenorrhea of 4 years' duration in a 24-year-old married woman. A course of 10 mg. NORLUTIN twice daily for 5 days was followed after 3 days by menses lasting about 5 days. Since no spontaneous menstruation occurred during the following 35 days, she was given another course of treatment with NORLUTIN, 10 mg. twice daily for 5 days. This was followed by menses.

When this patient was given ethisterone, 40 mg. twice daily for 5 days, no bleeding had ensued when she was seen 41 days later.

INDICATIONS FOR NORLUTIN: conditions involving deficiency of progestogen such as primary and secondary amenorrhea, menstrual irregularity, functional uterine bleeding, endocrine infertility, habitual abortion, threatened abortion, premenstrual tension, and dysmenorrhea.

PACKAGING: 5-mg. scored tablets (C. T. No. 882), bottles of 30.

REFERENCES: (1) Greenblatt, R. B.: *J. Clin. Endocrinol.* 16:869, 1956. (2) Hertz, R.; Waite, J. H., & Thomas, L. B.: *Proc. Soc. Exper. Biol. & Med.* 91:418, 1956.

MEDICAMENTA VERA

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50191

Favis, Edward Alfred, Fort Washington, Pa. (U. Philippines 1947)
Fealy, Jack, Miami Shores (George Washington U. 1951)
Fernandez, Manuel C., El Paso, Texas (Jefferson 1953)
Ferre', George Allan, Great Lakes, Ill. (U. Va. 1957)
Figueroa, Miguel Jr., Santurce, P. R. (New York M. C. 1948)
Finney, Roy Pelham Jr., Lakeland (South Carolina 1952)
Firestone, Melvin P., Eglin A. F. B. (Northwestern 1955)
Fitch, Charles Walter, Tampa (U. Tenn. 1953)
Fitzgerald, Joseph Hodges, Miami (U. Va. 1957)
Fleet, Harvey Meyer, Fort Walton Beach (Vanderbilt 1957)
Flipse, Thomas Edward, Miami (U. Miami 1957)
Foard, Milton Cowan, Leesburg (South Carolina 1953)
Ford, Elbert Sylvester Caldwell, Merion Station, Pa. (Vanderbilt 1939)
Fry, Richard McGruder, Ann Arbor, Mich. (Temple 1954)
Fuzy, Paul James Jr., Youngstown, Ohio (Harvard 1946)
Fyvolent, Joel David, Tampa (Lausanne U. 1955)

Gachet, Fred Smith Jr., Lakeland (Johns Hopkins 1957)
Genest, Aloria Stephen, Miami (St. Louis 1957)
Gerspacher, Thomas Stone, Miami (U. Louisville 1933)
Getz, Morton Ernest, Miami (Bowman Gray 1956)
Gibson, James Franklin, Tampa (Duke 1956)
Giddings, Marvin Alvin, Tampa (Emory 1957)
Gilbert, Arthur Ira, Miami Beach (U. Miami 1957)
Gillman, Arthur, Miami (U. Geneva 1954)
Giordano, Robert Paul, Sarasota (Chicago 1952)
Giovinco, Joseph, Tampa (Tulane 1957)
Gleich, Gerald, Canajoharie, N. Y. (U. Mich. 1956)
Golubovic, Zivomir, Miami Beach (U. Munich 1951)
Gould, Louis Nathan, Coral Gables (New York M. C. 1927)
Gray, Gene Woodrow, Birmingham, Ala. (Ala. 1957)
Groover, Robert Vann, Atlanta, Ga. (Emory 1957)

Haimes, Leonard, Miami (Hahnemann 1953)
Hall, James Alden, Lake City (Med. Evang. 1955)
Hamner, Bennie Rodgers, Birmingham, Ala. (Ala. 1957)
Harden, David Lee, Pensacola (Tulane 1957)
Hardman, William Wallace Jr., Winter Haven (Emory 1957)
Harris, Joan Osheroff, Miami Beach (U. Miami 1957)
Heiss, Harold Burgess, Miami (U. Miami 1957)
Helsper, James Thomas, Cocoa Beach (Jefferson 1947)
Hirsh, John Henry, New Rochelle, N. Y. (Flower, 5th Ave. Hosp. 1953)
Hodges, Charles Hubert Jr., Marianna (Emory 1957)
Holford, Fred DeWitt, Miami (U. Vermont 1956)
Holladay, William Edward Jr., Augusta, Ga. (Virginia 1952)
Holland, Charles Phillip, Palm Beach (U. Louisville 1954)
Holly, John Hayes Jr., Jacksonville (U. Miami 1957)
Howard, Woods Abernathy, Lakeland (U. Texas 1947)

Ifft, Robert Charles, Iowa City (Temple 1953)

Johnson, Curtis Corydon, Lake Worth (U. Buffalo 1953)
Johnson, Walter Hughes, New York (U. Tenn. 1940)
Jones, David Lewis, St. Petersburg (Western Reserve 1954)
Joseph, Julius Mortimer, New York (N. Y. U. 1934)

Kafka, Maximilian Martyn, Miami Beach (U. Md. 1924)
Kandel, William Isadore, Miami Beach (U. Miami 1957)
Kaszuba, Alexander, St. Petersburg (Friedrich Alexander U. 1948)
Kathe, John Henry, Coral Gables (Ohio U. 1957)
Kaye, Donald, Yonkers, N. Y. (N. Y. U. 1957)
Kesler, Robert Milton, Orlando (U. Va. 1954)
Killoran, Paul Joseph, Fort Lauderdale (Boston U. 1954)
Kirk, Michael James, South Miami (George Washington U. 1954)

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Kirkpatrick, James Leroy Jr., Atlanta, Ga. (Emory 1957)
Kitaif, James Myron Collins, Macon, Ga. (Ga. M. C. 1955)
Klein, Harry Adolph, St. Louis (St. Louis 1929)
Knorr, Keith Howard, Fort Walton Beach (Iowa M. C. 1954)
Knowles, John Little, Jacksonville (Ala. 1955)

Lampert, Ronald Marvin, New York (U. Tenn. 1957)
Lampkin, John Chadwick, Toledo, Ohio (U. Mich. 1956)
Landy, Jerome Jacob, Miami (U. Illinois 1950)
Lansden, Frank True, Winter Haven (Ohio U. 1956)
Lasichak, Andrew Gregory, Detroit (Jefferson 1940)
Lawrence, Joseph Woodruff, Fort Myers (Iowa U. 1937)
Levine, Robert Lee, Tampa (U. Md. 1953)
Levitt, Alan Bruce, Riverdale, N. Y. (Chicago 1956)
Lieberman, Warren Jay, Miami (Tulane 1957)
Lieurance, Richard Edward, Jacksonville (Tulane 1946)
Lindsey, Edwin Leon, Orlando (U. Tenn. 1956)
Lindsey, William Frederick, Augusta, Ga. (Ga. M. C. 1954)
Locke, Margaret Marie, St. Petersburg (U. Miami 1957)
Logan, John Bronson, Sarasota (Jefferson 1948)
Lynch, Harold John Jr., Miami Beach (Georgetown 1957)

MacCubbin, Don Aubrey, Durham, N. C. (Johns Hopkins 1957)
McCallum, Charles Alexander Jr., Birmingham, Ala. (Ala. 1957)
McDonald, James Kenneth, Augusta, Ga. (Ga. M. C. 1956)
McDonald, Lawrence Patton, Atlanta, Ga. (Emory 1957)
McNeil, James Porter Jr., New York (U. Va. 1952)
Maercks, Ralph Owen, Winston-Salem, N. C. (Bowman Gray 1957)
Marine, William Murphy, Fairhope, Ala. (Emory 1957)
Marsh, Robert Leslie, Lake Worth (New York M. C. 1949)
Martin, Calvin Wallace, Columbus, Ga. (U. Tenn. 1957)
Maxwell, Edgar James Jr., Thomson, Ga. (Ga. M. C. 1943)
Miles, George Gregory, New Orleans (Long Island, M. C. 1944)
Milledge, Robert Dempsey, South Miami (Emory 1957)
Mitchell, Joseph Alexander, Los Angeles (U. Miami 1957)
Moore, John Beverly III, Mount Vernon, Ill. (U. Illinois 1952)
Morris, John de LaSalle, Tampa (Cornell 1950)
Moses, Robert Jerome Jr., Miami Beach (Loyola 1948)

Nalebuff, Edward Alan, Brighton, Mass. (Tufts 1953)
Nash, Seymour Cy, Palm Beach (Washington U. 1956)
Nichols, Thomas Howard, Evansville, Ind. (Indiana U. 1952)

Oliver, George Charles Jr., Jacksonville (Harvard 1957)
O'Neill, James Frank, Miami (Duke 1957)
Onkey, Richard Gale, Hialeah (U. Tenn. 1957)
Ott, Franklin Bernard, Maplewood, N. J. (Loyola 1945)

Pace, Leonard D., Forest Hills, N. Y. (George Washington U. 1957)
Palmer, David Bartow, Stamford, Conn. (Columbia 1954)
Palmer, Henry George Jr., Atlanta, Ga. (Emory 1957)
Park, Fred Eugene, Long Island, N. Y. (U. Miami 1957)
Parrish, Henry Mack, Ocala (U. Penn. 1953)
Paschall, Homer Alvin, Plant City (Bowman Gray 1957)
Pauk, Zdenek Daniel, Miami (Iowa U. 1956)
Perle, Martin Harold, West New York, N. J. (Indiana U. 1949)
Perlman, Aaron Martin, Jacksonville (U. Miami 1957)
Perry, Ronald Howard, Jacksonville (U. Tenn. 1956)
Phillips, Curtis Manning Jr., Jesup, Ga. (Ga. M. C. 1943)
Phillips, Morton Fred, Milwaukee (Marquette 1953)
Pittman, Roy Clinton, Clearwater (South Carolina 1956)
Platt, Marvin Stanley, Pikesville, Md. (U. Md. 1956)
Platten, Phillip Matthew, Cleveland (Ohio U. 1954)
Pooser, Francis Shingler, Lake Wales (Emory 1957)
Porto-Perez, Francisco, Tampa (U. Havana 1949)
Potash, Irwin Michael, Miami Beach (Jefferson 1953)
Poteete, Floyd Herod Jr., Pahokee (Northwestern 1951)

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Price, Robert Cornelius Jr., Tampa (U. Cinn. 1953)
Principato, Dominick Joseph, New York (Tulane 1952)

Quick, James Chilton, Clendenin, West Va. (Washington U. 1943)

Radigan, Leo Robert, Indianapolis (Indiana U. 1947)
Radin, Arthur, Miami (U. Miami 1957)
Ranes, Raymond David, Key Biscayne (Bowman Gray 1956)
Rape, William Chalmers, New Smyrna Beach (Emory 1957)
Redd, Henry Jefferson Jr., Baltimore, Md. (Johns Hopkins 1957)
Resnick, Benjamin, New Rochelle, N. Y. (U. Edinburgh 1932)
Ribot, Seymour, Orange, N. J. (U. Louisville 1946)
Richards, James Fred Jr., Atlanta, Ga. (North Carolina 1957)
Roberts, Daniel, Miami (Bowman Gray 1957)
Robinson, James Lee Jr., Brooklyn (U. Penn. 1932)
Robinson, John Ritchey, Kankakee, Ill. (Northwestern 1940)
Rogers, Robert Ernest, West Palm Beach (U. Miami 1957)
Rogers, Robert Jay, Richmond, Ind. (Med. Evang. 1956)
Rosemond, Robert Malone, Charleston, S. C. (Duke 1953)
Ryon, Alden Billings, Miami (U. Cinn. 1953)

Sachs, Julian Spencer, Washington, D. C. (U. Geneva 1954)
Sacks, Sidney, Miami Beach (U. Md. 1946)
Sadwin, Arnold, Miami (Chicago 1956)
Sager, Samuel Ott, Bartow (Duke 1953)
Sanders, Jack Ernest, Panama City (U. Miami 1957)
Sarlin, Morton Bruce, New York (Tulane 1957)
Saunders, Earl Nicholas, Danville, Va. (U. Miami 1957)
Schulman, Martin Lewis, Brooklyn (Albany 1957)
Schwartz, Melvin Jay, Wilmington, N. C. (Duke 1957)
Selzer, Melvin Lawrence, Ann Arbor, Mich. (Tulane 1952)
Serrins, Alan Jack, Coral Gables (U. Miami 1957)
Setnor, Jules Roswell, Longmeadow, Mass. (Syracuse U. 1935)
Shapiro, Daniel Martin, Miami (N. Y. U. 1944)
Shapiro, Jerome Benjamin, Coral Gables (N. Y. St. U. 1957)
Sherman, Marion Moore Jr., Hampton, Va. (U. Va. 1952)
Shively, John Adrian, Bradenton (Indiana U. 1946)
Siek, Hilmer Gerard Jr., Belleair Beach (Columbia 1952)
Simonson, Louis, Miami (U. Leyden 1956)
Small, David, Miami (U. Miami 1957)
Smith, Henry Roy III, Coral Gables (Ga. M. C. 1956)
Smith, Norman Ty, Fort Lauderdale (Harvard 1957)
Smotrilla, Margaret Mary, Miami (U. Miami 1957)
Solomon, Alan, New York (Duke 1957)
Southerland, Wesley LaMarr, Miami (U. Miami 1957)
Spanjers, Arnold Joseph, Winter Haven (U. Minn. 194
Sporn, Max, Miami Beach (Chicago 1954)
Spoto, Angelo Peter Jr., Tampa (Duke 1957)
Steir, Bruce Saul, Miami Beach (U. Miami 1957)
Stephen, Ralph Merrill, Atlanta, Ga. (Chicago 1951)
Stewart, Charles Calloway, Donaldsonville, Ga. (Emo 1952)
Stolove, Sender, Miami (Tulane 1956)
Stone, James Lovell, Tampa (Jefferson 1956)
Strasser, Noel Faine, Westchester, Ill. (George Washington U.)
Stuckey, Walter Jackson Jr., Metarie, La. (Tulane 195
Sussman, Herbert Bernard, Los Angeles (Tulane 1957
Sylvan, Melvin Manuel, Miami Beach (Wayne 1941)

Tannozzini, Joseph Richard, Miami (Georgetown 195
Taubel, David Edward, Fort Lauderdale (U. Penn. 19

(Continued on page 521)

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• **allays bronchial spasm** • **liquefies tenacious secretions** • **suppresses allergic manifestations**

The ingredients of Hydryllin Compound are proportioned to provide high therapeutic response.

Each 4 cc. (one teaspoonful) contains:

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Ammonium chloride	30.0 mg.	Alcohol 5% (v/v)	

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Each tablet contains:

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Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
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Propylparaben	1 mg.

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The Achrocidin formula is particularly valuable in treating acute respiratory infections during epidemics and other outbreaks.

In addition to *rapid symptomatic improvement,* Achrocidin offers *prompt control of the bacterial superinfection* frequently responsible for such disabling complications as pneumonia, otitis media, sinusitis, bronchitis, pneumonitis to which the patient may be vulnerable.

The comprehensive Achrocidin formulation includes both *Achromycin* Tetracycline — broad-spectrum antibiotic action — and *analgesic components* recommended for rapid relief of malaise, headache, muscular pain, pharyngeal and nasal discharge.

Adult dosage for Achrocidin Tablets and new, caffeine-free Achrocidin Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

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at bedtime

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(Continued from page 518)

Taylor, William Gramer, West Palm Beach (U. Tenn. 1956)
Teichner, Ronald, Miami (U. Illinois 1953)
Terezakis, George Ernest, Orlando (Emory 1957)
Tillman, Ralph Allen, Spartanburg, S. C. (Ga. M. C. 1957)
Tolmach, Robert Scott, Houston, Texas (N. Y. U. 1945)
Towbin, Samuel, Pompano Beach (U. Colorado 1929)
Treadwell, Tandy Walter Jr., Miami (Vanderbilt 1957)
Tumlin, Paul Franklin, Milledgeville, Ga. (Ga. M. C. 1955)

Unger, Hugh Sheldon, Brooklyn (U. Tenn. 1957)
Ungerleider, John Thomas, Shaker Heights, Ohio (Western Reserve 1957)
Updegraff, Ambrose Gavitt, St. Petersburg (Iowa U. 1955)

Vaughen, Justine Liesel (f), Ann Arbor, Mich. (Temple 1954)
Vizzi, Ferdinando Freddie, Metairie, La. (Tulane 1956)

Weiner, Myron Frederick, Dallas, Texas (Tulane 1954)
Weisbart, Myron Herbert, Delmar, N. Y. (Columbia 1950)
Weiser, Albert, Fall River, Mass. (Boston P&S 1941)
Weiser, Frank Morton, Boston (Harvard 1957)
Weiss, Sherwyn Lee, Columbia, S. C. (U. Illinois 1954)
Wells, Leonard Rudolph Jr., Lake City (U. Louisville 1946)
Wells, Sarah Lou, Miami (U. Miami 1957)
Wenner, Robert Bruce, Pensacola (Temple 1954)
White, Robert Campbell, Pensacola (U. Miami 1957)
Wilbur, Ronald Eugene, Rochester, Minn. (U. Kansas 1946)
Wilcox, William Curtis-Nash, Atlantic Beach (Tulane 1957)
Williams, Moke Wayne, Fort Lauderdale (U. Cinn. 1953)
Williams, Sylmar Nance, (Col.), Lake Wales (Howard U. 1957)
Wilson, Robert Manton Jr., Richmond, Va. (Virginia 1943)
Winslow, Kenneth Lane, Detroit (U. Mich. 1949)
Wolff, Theodore Martin, Miami (Emory 1957)
Wood, James Garland Jr., Birmingham, Ala. (U. Colorado 1945)
Woolsey, Robert Dean, St. Louis (Harvard 1937)
Wunderlich, Ray Charles Jr., Tyndall A. F. B. (Columbia 1955)

Yates, Basil Manley, Houston, Texas (U. Tenn. 1950)

Zaias, Nardo, Miami Beach (U. Miami 1957)
Zimmerman, Aaron Harold, Miami (U. Miami 1957)
Zucker, Reuben, Waterbury, Conn. (Yale 1944)

OBITUARIES

Gail Ellsworth Chandler

Dr. Gail Ellsworth Chandler of Miami died in that city on Dec. 15, 1956. He was 63 years of age.

Born in Carman, Ill., on Aug. 2, 1893, Dr. Chandler received his elementary education in the public schools of his native state. He attended the Jefferson Medical College of Philadelphia, where he was awarded the degree of Doctor of Medicine in 1918. For some years he served in the United States Navy as a lieutenant commander.

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In 1925, Dr. Chandler came to Miami from Evanston, Ill., and entered the private practice of medicine there, specializing in ophthalmology and otolaryngology. He was associated with the late Dr. Bascom H. Palmer from 1925 until the death of Dr. Palmer in September 1954. Locally, he was a member of the Miami Rotary Club and was a Mason.

Dr. Chandler had for more than three decades been a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He was also a fellow of the American College of Surgeons and was certified by the American Board of Otolaryngology. He held membership in the Florida Society of Ophthalmology and Otolaryngology and the American Academy of Ophthalmology and Oto-Laryngology.

Alexis Merritt Melvin

Dr. Alexis Merritt Melvin of South Miami died suddenly on June 18, 1957, of a heart attack. He was 77 years of age.

A native of Philadelphia, Dr. Melvin received his medical training in that city. He was awarded the degree of Doctor of Medicine by the Jefferson Medical College of Philadelphia in 1904. Before locating in Miami, he practiced medicine in Royersford, Pa. During World War I, he served as a captain in the Medical Corps in the European theater. His interests in Miami included active membership in the Camera Club of Miami and the Blue Lodge of the Masons.

Dr. Melvin was licensed to practice medicine in Florida in 1933, and his specialty was internal medicine. He was a member of the Dade County Medical Association, the Florida Medical Association, the American Medical Association, the Southern Medical Association, and the American Congress of Physical Medicine.

Surviving are the widow, Mrs. Dorothy F. Melvin, of Miami; one brother, Frank Melvin, and two sisters, Mrs. William Trimble and Mrs. Jay Schmidt, all of Philadelphia.

Merrick D. Thomas Sr.

Dr. Merrick D. Thomas Sr. of Miami died in a local hospital on July 9, 1957. He was 80 years of age and had been hospitalized for two months following his wife's death.

(Continued on page 537)



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INCREMIN offers l-Lysine for protein utilization, and essential vitamins noted for outstanding ability to stimulate appetite, overcome anorexia.

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Each INCREMIN Tablet
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l-Lysine	300 mg.	Pyridoxine (B_6)	5 mg.
Vitamin B_{12}	25 mcgm.	(INCREMIN Drops contain 1% alcohol)	
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Dosage only 1 INCREMIN TABLET or 10-20 INCREMIN Drops daily.

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most broadly effective thera
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Eighty-seven patients with various infections of the skin were treated over a period of six weeks with [Signemycin]. Excellent or good results were achieved in sixty-seven, including seven of twenty-two patients refractory to other antibiotics."

Lewis, H. H.: Frumess, G. M., and Finschel, E. J.: Rocky Mountain M. J. 54:806 (Aug.) 1957.

"Results of treatment with oleandomycin-tetracycline of 50 infections [mostly respiratory] due to resistant organisms and 40 infections [respiratory, skin, urinary infections] due to resistive organisms are very encouraging. In some of these patients, [signemycin] was lifesaving, and in others surgery was made unnecessary. This confirms other reports."

Lubin, H.: Antibiotic Med. & Clin. Therapy 4:174 (March) 1957.

Based on case reports documented by independent investigators in 26 countries abroad, the clinical response obtained with Signemycin in 1404 patients with a wide variety of infections was successful in 1329 patients; in 13 cases only was it necessary to discontinue therapy because of side effects.

Report on 1404 Cases Treated with Signemycin: Medical Department, Pfizer International. Available on request.

In 50 nonselected patients, Signemycin "...appears to be effective in the treatment of most general surgical infections, including virulent staphylococcus aureus infections. In some cases these infections had been clinically resistant to other antibiotics. The drug is apparently well tolerated."

Levi, W. M., and Kredel, F. E.: J. South Carolina M. A. 53:178 (May) 1957.

Of 50 patients with various infectious processes, 26 had not responded to previous antibiotic therapy. With Signemycin "Ninety-six per cent of the mixed infections were clinically controlled. . . . and in none of the cases was there any reason to discontinue the drug."

Winton, S. S., and Chesrow, E.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 55.

Signemycin in 79 patients with severe soft tissue infections: "The average response of these cases was excellent and inflammatory symptoms subsided with almost uniform rapidity....The magnitude and incidence of surgical intervention was reduced....Side reactions were minimal. . . ."

LaCaille, R. A., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67.

Five groups of patients (total 211) with acne were treated with one of five antibiotic agents, including Signemycin (55 cases). "The results were evaluated taking into consideration the usual response to such conservative conventional therapy and the rapidity of response." In 8 weeks, Signemycin rapidly attained and maintained the highest percentage of efficacy of antibiotic agents tried.

Frank, L., and Stritzler, C.: Antibiotic Med. & Clin. Therapy 4:419 (July) 1957.

In the treatment of 78 patients with tropical infections, some complicated by multiple bacterial contamination or present for years, Signemycin was found to be "...an exceptionally effective agent," requiring smaller doses and less extended periods of therapy than with the tetracyclines alone, and "caused no notable toxic reactions."

Loughlin, E. H., and Mullin, W. G.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 63.

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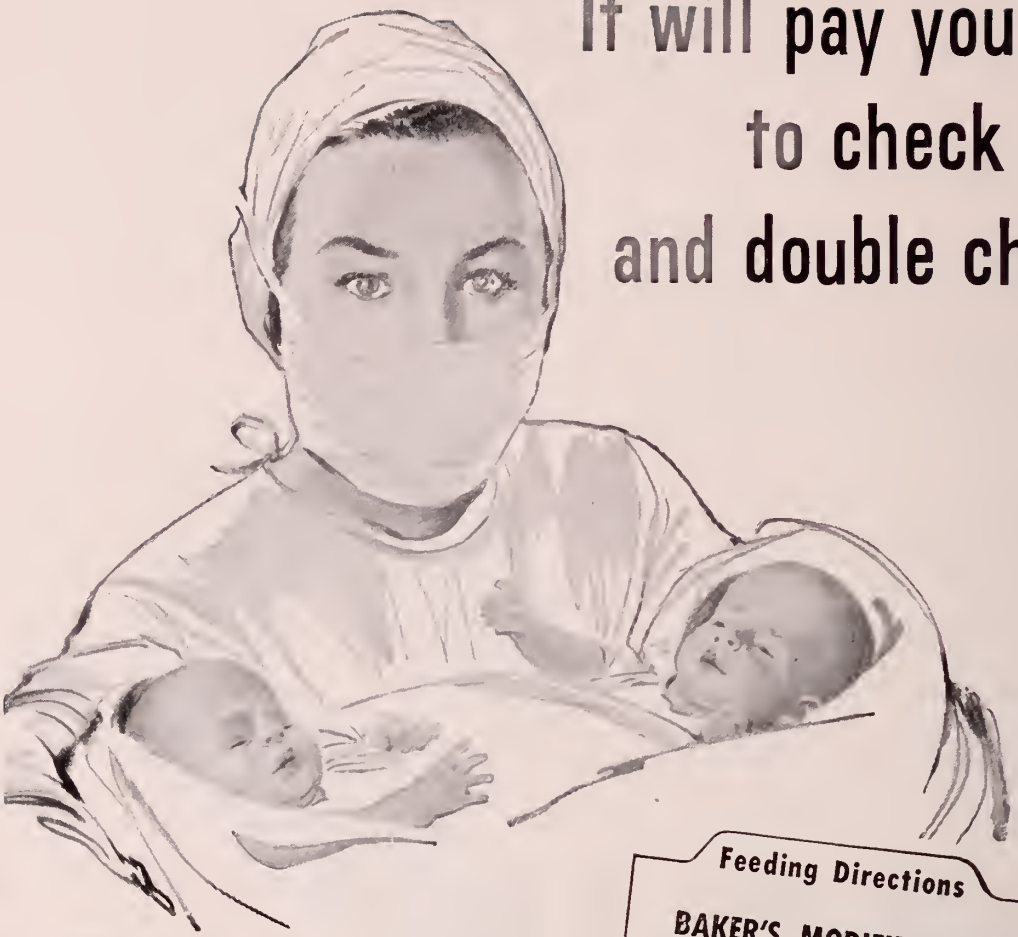
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Baker's Modified Milk is a *complete* infant food — contains *all* requirements for complete infant nutrition . . . It is available in two time-saving forms — easy-to-prepare *Baker's Liquid* and *Baker's Powder*, the latter particularly adaptable for prematures and for complemental and supplemental feedings. Both forms are low in cost — less than a penny per ounce of formula.

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FIRST WEEK AT HOME — 1 part Baker's to 1½ parts cool water.

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In the hospital — and at home.



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links freedom from anginal attacks with a shelter of tranquility

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For angina patients—perhaps the next one who enters your office—won't you consider new CARTRAX? This doubly effective therapy combines PETN (pentaerythritol tetranitrate) for lasting vasodilation and ATARAX for peace of mind. Thus CARTRAX relieves not only the anginal pain but reduces the concomitant anxiety.

Dosage and supplied: begin with 1 to 2 yellow tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. This may be increased for maximal effect by switching to *pink* tablets (20 mg. PETN plus 10 mg. ATARAX). In bottles of 100.

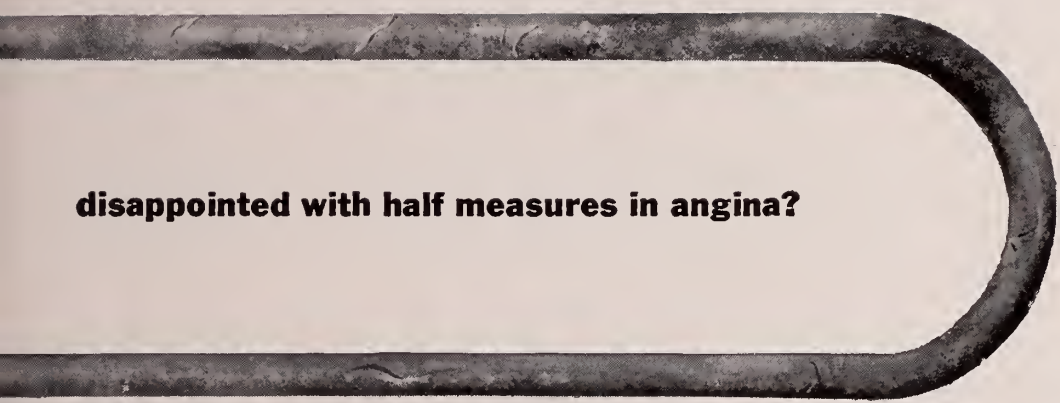
CARTRAX should be taken *before* meals, on a *continuous* dosage schedule. Use with caution in glaucoma.

1. Russek, H. I.: J. Am. Geriat. Soc. *4*:877 (Sept.) 1956.

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disappointed with half measures in angina?
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VOLUME XLIV
NUMBER 5

Current Concepts in

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Successful infant feeding depends on effective planning of the newborn's nutritional regimen. The first feeding, 12 hours after birth, may consist of a prelacteal solution of KARO® Syrup. This should be offered in one or two ounce amounts at two hour intervals for 24 to 48 hours to fulfill the high water requirement during the first week of life. Breast feeding may be initiated on the second day for five minute intervals to obtain colostrum and stimulate breast secretion. However, the prelacteal feeding is continued thereafter and between nursings.

Artificial feeding is offered on the second day if breast feeding is denied. Small infants are fed at three hour intervals and large infants at four hour intervals. The initial formula usually is a low caloric milk mixture to enable gradual adaptation of the feeding to the infant's tolerance. Concentration of the formula is gradually increased at intervals of several days, in the absence of digestive disturbances. The infant should be fed in a semi-reclining position, burped during and after feeding, and kept on his right side or abdomen undisturbed for an hour.

The same problems of infant feeding recur from generation to generation, but solutions may differ with each era. The carbohydrate requirement for all infants is as completely fulfilled by KARO Syrup today as a generation ago. Whatever the type of milk adapted to the individual infant, KARO Syrup may be added confidently because it is a balanced mixture of low molecular weight sugars, readily miscible, well tolerated, palliative, hypoallergenic, resistant to fermentation in the intestine, easily digestible, readily absorbed and non-laxative. It is readily available in all food stores.

Rx FIRST FORMULAS FOR NEWBORNS ADAPTED ACCORDING TO TOLERANCE

FORMULA I 11 cals./oz.
*Whole Milk 8 oz.
Water 12 oz.
Karo ½ oz.
3½ oz. x 6 q 4h.

FORMULA I 12.5 cals./oz.
**Evap. milk 4 oz.
Water 14 oz.
Karo ½ oz.
3½ oz. x 6 q 4h.

FORMULA I 11 cals./oz.
Dried milk 4 tbsp.
Water 20 oz.
Karo ½ oz.
3½ oz. x 6 q 4h.

FORMULA III 16 cals./oz.
Whole milk 10 oz.
Water 10 oz.
Karo 1 oz.
3½ oz. x 6 q 4h.

FORMULA III 20 cals./oz.
Evap. milk 6 oz.
Water 12 oz.
Karo 1 oz.
3 oz. x 6 q 4h.

FORMULA III 18 cals./oz.
Dried milk 6 tbsp.
Water 20 oz.
Karo 1 oz.
3½ oz. x 6 q 4h.

FORMULA II 13.5 cals./oz.
Whole milk 9 oz.
Water 11 oz.
Karo ¾ oz.
3½ oz. x 6 q 4h.

FORMULA II 16 cals./oz.
Evap. milk 5 oz.
Water 13 oz.
Karo ¾ oz.
3 oz. x 6 q 4h.

FORMULA II 14.5 cals./oz.
Dried milk 5 tbsp.
Water 20 oz.
Karo ¾ oz.
3½ oz. x 6 q 4h.

*Whole lactic acid milk formulas may also be prepared from whole cow's milk.

**Whole lactic acid milk formulas may also be prepared from evaporated cow's milk.

Adapted from Nelson's Pediatrics, Saunders, Phila. 1954

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Monilial
overgrowth
is a factor

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Tetracycline (phosphate-buffered) and Nystatin

Combines ACHROMYCIN V with NYSTATIN

ACHROSTATIN V combines ACHROMYCIN† V . . . the new rapid-acting oral form of ACHROMYCIN† Tetracycline . . . noted for its outstanding effectiveness against more than 50 different infections . . . and NYSTATIN . . . the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients who are prone to monilial overgrowth during a protracted course of antibiotic treatment.

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ACHROSTATIN V CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin.

dosage:

Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

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Flu Fight

Drug Firms Speed Vaccine Output, Bu Will the U.S. Need

Asiatic Virus Raises Th Government Buys, F nd Hens Have to H

en Attack, Rapid S

8 STUDENTS ON FLIGHTS TO U. S. HAVE ASIAN FLU

New York, Aug. 15 (AP Laboratory tests on e foreign exchange student arrived Aug. 8 show they victims of Asiatic flu, the health department repo today. The eight arrived plane from Europe.

Twenty-nine other stud suffering from influenza rived Tuesday from Rot dam on the ship Arosa Sky. One, Nicholas Memmos, Greek exchange student, die yesterday. Six of these stu dents were released today the others are to be r tomorrow. It has not termined whether died from Asiatic

Pe vac izat flo the ority States

THE INFLUE

How Deadly Will it
What Can We Do a

IF

Ansv

A n —is sh around now h

War on Mutant A

Florence was in the grip of an epi- of colds, coughs and fevers, astrolo- . . . declared that it was caused by influence of an unusual conjunction of ts. This sickness known as "infl —Chronicles of 1200-1470.

combat new r ce," a worldwide week in respons the Far East. Si World Health which collects i around the globe nens of the ene In more than a ling those of th

Asian Flu: the Outlook

Asian influenza will hit the U.S. this fall before mass immunization can be effective, and the nation faces an epidemic which may strike 15 million to 30 million people. The disease is relatively mild (in no way comparable to the killing "Spanish flu" of 1918-19), and is likely to cause only a small number of deaths among the feeble young and enfeebled old. But it may compel 10% to 20% of the population in affected areas to tak thus

W quie a co pect Ser pop

U.S. Fighting A

The War On Asiatic Flu

There's cause for concern about Asiatic flu, but scientists and public health officials see no reason for anyone to panic.

First shipments of the vaccine against the new influenza strain have arrived in Chicago, setting off a flood of telephone calls from worried patients to doctors, and from doctors to drug suppliers. This is a nor pattern of mass fear and is understan

The of the

Even though Salk vaccine priorities were necessary, the regulation produced administrative headaches, public complaints and probably a gray, if not a black market. When regulation i invoke it. would

PUBLIC HEALTH

Influenza A

➤ INFLUENZA, one of the most dictable of communicable diseases, ing "on cat feet" across the natio now. It has already struck once th in mild epidemic form at an Air base in Colorado. When and how s it will strike again is a perennial r public health authorities.

It will probably not lie dorma the rest of the winter months. At th

to counteract
complications from
"ORIENTAL FLU"

EMIC
using It?

ATCH "ASIATIC" FLU—

e New Virus Threat From Orient

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STEARATE (Erythromycin Stearate, Abbott)
effective against staph-, strep- and pneumococci
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SELECTION OF SUITABLE SULFONAMIDE IS OF PRIME IMPORTANCE IN LONG-TERM THERAPY OF URINARY TRACT INFECTIONS

Drug Must Meet High Standards of Efficacy and Safety

In recent years sulfonamide therapy for urinary tract infections has gained new popularity because the original drugs have been replaced by more soluble, less toxic and more effective sulfas.[1] Gram for gram, a single sulfonamide featuring high solubility and low acetylation is unsurpassed for efficacy and safety — especially in prolonged therapy.

An editorial in the Journal of the American Medical Association states that sulfonamides are successful in 90 per cent of urinary tract infections, and "... should be tried first."[2] There are many properties a sulfonamide should possess before it can be claimed to be efficacious and safe. "Thiosulfil,"® brand of sulfamethizole, is considered to be one of the "... most acceptable sulfonamides for treatment of urinary tract infections ..."[3]

Broad Bacteriostatic Index

"Thiosulfil" is effective against most gram negative and gram positive organisms commonly found in the urinary channels.

High Plasma — Urine Levels

"Thiosulfil" is rapidly absorbed and excreted, achieving high antibacterial levels in the urine and throughout infected tissue, with negligible penetration into red blood cells.

High Solubility

"Thiosulfil," in both the active and acetylated forms, is highly soluble in urine over a wide pH range, thus permitting effective action with minimal side effects. Alkalinization is not required; fluids may be restricted rather than forced.

Low Acetylation

"Thiosulfil" is virtually unacetylated. As much as 90-95 per cent remains in the free therapeutically active form. Virtually all of a given dose is therefore available for antibacterial action.

In a long-term clinical study, patients with incurable chronic urinary infections were kept symptom free for as long as five or six years on a maintenance dose of one or two tablets of "Thiosulfil" daily.[4] In another evaluation, 20 patients were given 25-100 grams of "Thiosulfil" over a period of 20-90 days without incidence of side reactions.[5] Goodhope[6] reports that during 30 months of clinical use with "Thiosulfil," no evidence occurred of exanthemata, urticaria, emesis, fever, hematuria and crystalluria.

Recommended Dosages: 0.5 Gm. four times daily. The pediatric dosage is 30 to 45 mg. daily per pound of body weight. If voiding occurs during the night, an extra half-dose should be given. Fluids may be restricted rather than forced.

Availability: Tablets, 0.25 Gm. (bottles of 100 and 1,000). Suspension, 0.25 Gm. per 5 cc. (bottles of 4 and 16 fl. oz.).

Bibliography on request.

AYERST LABORATORIES
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5734

why wine in digestive disorders?



Although the effects of wine on the digestive system have been discussed for centuries, it has been only in recent years that many of its physiological attributes have been determined.

WINE AND THE SALIVARY GLANDS—The increase in salivary flow following a moderate intake of wine is apparent almost immediately,[1] such increase being attributed to direct sensitization of secretory nerve endings.[2]

WINE AND GASTRIC SECRETION—With a pH averaging 3.2, wine resembles gastric juice more closely than does any other natural beverage. Its tannins, organic acids and salts of these acids serve as buffering agents to maintain this pH. Relatively low in content of alcohol, table wine has been found to stimulate gastric secretion and induce production of gastric juice high in hydrochloric acid, sodium chloride, rennin and pepsin.[3]

WINE AND THE DIGESTIVE TRACT—With its low concentration of alcohol, wine in moderate consumption has been found to induce a marked increase in biliary flow.[4] This, together with increased function of pancreatic enzymes, may thus encourage better digestion of fatty foods.

THEREFORE—IN THE TREATMENT OF DIGESTIVE DISORDERS—Wine is being widely recommended in the treatment of anorexia, hypochlorhydria without gastritis, mucous colitis, spastic constipation and diarrhea, and in digestive disorders stemming from emotional tension and anxiety.

These and other modern ℞ uses for wine are discussed in the brochure "Uses of Wine in Medical Practice." For your free copy write—Wine Advisory Board, 717 Market Street, San Francisco 3, California.

1. Winsor, A. L. and Strangin, E. I.: J. Exper. Psychol. 16:589 (1933).
2. Beazell, J. M., and Ivy, A. C.: Quart. J. Studies on Alc. 1:45 (1940).
3. Faray, G., and Weissenbach, R. J.: Hôpital 25:306 (1937).
4. Okada, S.: J. Physiol. 49:457 (1915).

For Speedy Return To Normal Nutrition

Meat...

in the congestive phase of cardiac disease

Meat fits well into the moderate-protein, restricted-sodium, acid-ash diet currently recommended for many patients with congestive cardiac failure.[1]

The protein of meat—in the proportionate arrangement of its essential amino acids—closely approaches the quantitative proportions needed to promote human tissue synthesis and repair. For this reason lean meat proves important in maintaining positive nitrogen balance without excessive protein intake.

The sodium content of meat prepared without added salt is relatively low. Per 100 grams, beef muscle meat shows approximately 50 mg. of sodium, lamb 90 mg., pork 60 mg., and veal 50 mg.[2]

The acid ash of meat aids in the promotion of diuresis.

The easy digestibility of meat is a prime requisite of foods specified for the patient with congestive cardiac disease.

In addition to these important features, meat contributes other nutritional factors essential in any convalescence —the B vitamins thiamine, riboflavin, niacin, pantothenic acid, B_6, and B_{12}, and the minerals iron, phosphorus, potassium, and magnesium.

1. Odell, W. M.: Nutrition in Cardiovascular Disease, in Wohl, M. C., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Philadelphia, Lea & Febiger, 1955, p. 699.
2. Bills, C. E.; McDonald, F. G.; Niedermeier, W., and Schwartz, M. C.: Sodium and Potassium in Foods and Waters, J. Am. Dietet. A. *25*:304 (Apr.) 1949.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

(Continued from page 522)

Born in Gold Hill, Ala., in 1877, Dr. Thomas received his medical training at Columbia University College of Physicians and Surgeons in New York, where he was graduated in 1904. He served internships at the New York Lying-In Hospital and the City Hospital at Blackwell's Island, New York.

Dr. Thomas entered the private practice of medicine in New Rochelle, N. Y., and one year later returned to his native state, locating in Opelika. In 1921 he left Alabama for Florida and established an active practice in general medicine in Miami, which he continued to conduct until two months prior to his death. Locally, he was for many years an active member of the Order of Shrine and of the Benevolent and Protective Order of Elks.

A member of the Dade County Medical Association, Dr. Thomas was also a member of the Florida Medical Association, in which he had held membership for three decades. In addition, through the years he was affiliated with the American Medical Association.

Survivors include one son, Dr. Merrick D. Thomas Jr., of Miami; two daughters, Mrs. Eugene King, of Miami; and Mrs. Minette Scarbrough, of Hollywood; three brothers including Dr. Edwin C. Thomas, of Miami; two sisters, three grandchildren and three great-grandchildren.

William Daniel Nobles

Dr. William Daniel Nobles of Pensacola died on Oct. 3, 1956 in that city. He was 76 years of age.

Born in Escambia County, near Pensacola, on April 7, 1880, Dr. Nobles acquired his elementary education in the schools of that county and then attended the Pensacola Business College. He received his medical training at the Atlanta College of Physicians and Surgeons, later Emory University School of Medicine, and was awarded the degree of Doctor of Medicine in 1907. Returning immediately to Pensacola, he engaged in the practice of general surgery there for almost half a century.

In 1909, Dr. Nobles was elected city physician and health officer, a post he held for 22 years. He then became company surgeon for the Louisville and Nashville Railroad, retiring from this position in 1954 after 20 years of service. Fraternally, he was a thirty-second degree Scottish



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Rite Mason, a Shriner and a member of Zellica Grotto No. 60. He held membership in the Gadsden Street Methodist Church. His business associations included membership on the Board of Directors of the First Bank and Trust Company and the Pensacola Loan and Savings Bank.

This veteran Pensacola surgeon received wide recognition as a pioneer of the medical profession in the area and also for his service to the state. He was for years a member of the Florida State Board of Health and a member of the State Medical Examining Board.

Dr. Nobles had for nearly 50 years been a member of the Escambia County Medical Society and was a past president of that organization. He was a life member of the Florida Medical Association, having become a member in 1908. He also held membership through the years in the American Medical Association and the Southern Medical Association.

Noah Tilden Counts

Dr. Noah Tilden Counts of Cocoa died at the Wuesthoff Memorial Hospital in Rockledge on June 24, 1957, after suffering a heart attack at his home. He was 81 years of age.

Born near Counts, Va., in 1876, Dr. Counts was educated in his native state. He received his medical training at the Medical College of Virginia, where he was awarded the degree of Doctor of Medicine in 1907. After practicing in Virginia for 10 years, he came to Florida in 1917. He located in Cocoa and continued to practice there for nearly 40 years. For 12 years he had been in somewhat poor health following an automobile accident, but continued to engage in the practice of his specialty of opthalmology and otolaryngology until two and a half years prior to his death.

Dr. Counts was a member of the Brevard County Medical Society and had held membership in the Florida Medical Association since 1927. He also was a member of the American Medical Association and of his specialty groups.

Surviving are the widow, Mrs. Helen Varr Counts, of Cocoa; three sons, Willard Counts, of Aily, Va., Wade Counts, of Royal Oak, Mich., and Arvill Counts, of Birmingham, Mich.; and two daughters, Mrs. G. C. Rasnick and Mrs. G. W. Powers, both of Hazel, Va.

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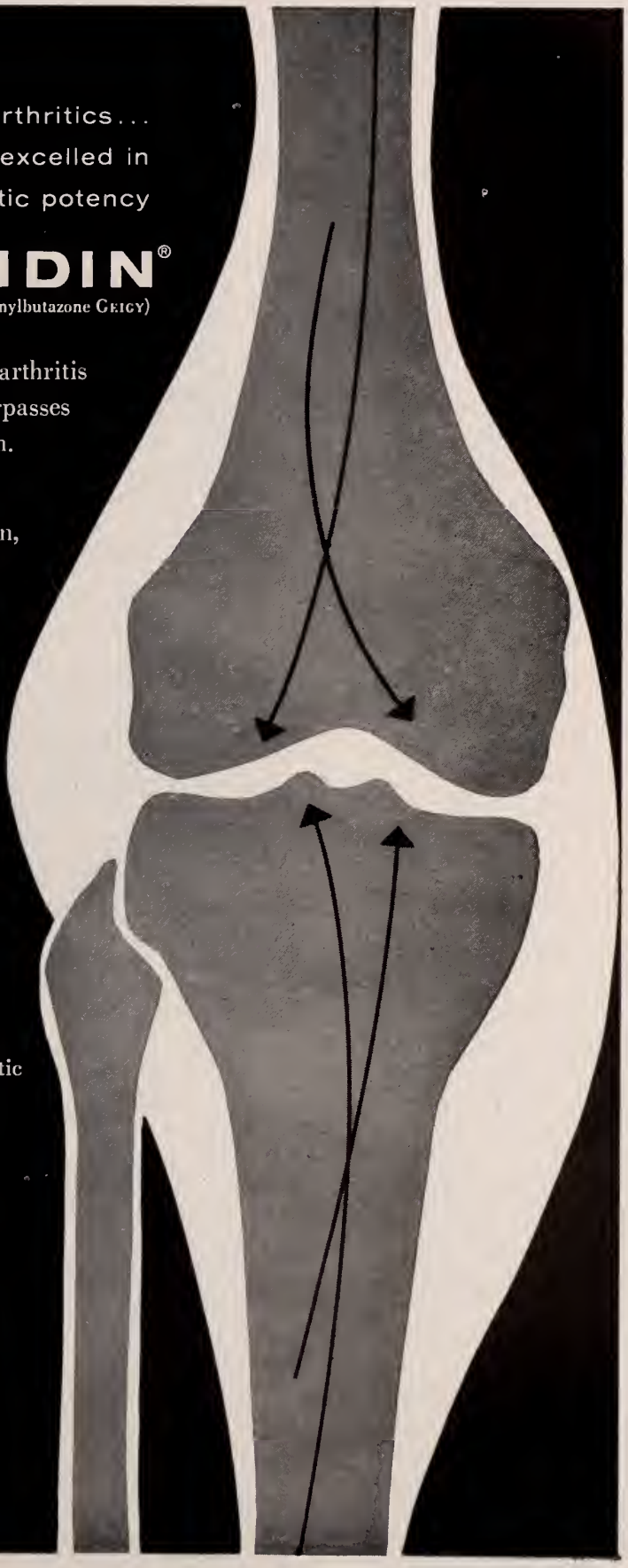
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KYNEX*

SULFAMETHOXYPYRIDAZINE LEDERLE

w authoritative studies prove that KYNEX sage can be reduced even further than that ommended earlier.[1] Now, clinical evidence s established that a single (0.5 Gm.) tablet intains therapeutic blood levels extending ond 24 hours. Still more proof that KYNEX nds alone in sulfa performance—

owest Oral Dose In Sulfa History—0.5 Gm. tablet) daily in the usual patient for main- ance of therapeutic blood levels

igher Solubility—effective blood concentra- ns within an hour or two

ffective Antibacterial Range—exceptional ectiveness in urinary tract infections

onvenience—the low dose of 0.5 Gm. (1 tab-) per day offers optimum convenience and eptance to patients

NEW DOSAGE

The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

Tablets:
Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup:
Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

[1] Nichols, R. L. and Finland, M.: J. Clin. Med. 49:410, 1957.

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The President Reports

This is being written in the first hours of quiet in the morning, with the children in school, feeling the cool breeze that portends relief from the long summer's heat. It seems only the other day that summer was just beginning and with it another year for the Woman's Auxiliary.

We have been busy with primary responsibilities; our husbands, children and homes. Now, back in the regular routine, we can turn our thoughts to helping our husbands in their chosen profession. That is the underlying purpose of our activities and the sole reason for our existence as an organization. It is toward this end that we are faced with what proved to be the busiest month of the year, at least for two people, the President and President-Elect of the Auxiliary.

The first of October found us in Pensacola for the Fall Board Meeting and Conference for State Officers, State Chairmen, District Chairmen, County Presidents, Presidents-Elect and Chairmen. We met in Pensacola because the Board believed it would benefit the entire Auxiliary to meet in that section. With the annual convention in south Florida for some time past, it posed an undue hardship on members from north and west Florida to come to the southern section of the state for our Board meeting also.

We had an unusual program in that we devoted the day of the Conference to group discussion under the inspired leadership of Mrs. Paul C. Craig, of Wyomissing, Pa., President of the Woman's Auxiliary to the American Medical Association. The problems were those that Conference members desired discussed as determined by questionnaires sent out in mid-summer.

We had a fruitful session where we learned from each other to look objectively at our activities and to evaluate our methods of achieving them.

We were royally entertained by the Woman's Auxiliary to the Escambia County Medical Society, with dinner one night at the Country Club

(Continued on page 545)

now "... *care of the man rather than merely his stomach.*"[1]



"Milpath"

Miltown® + *anticholinergic*



controls

gastrointestinal dysfunction

at cerebral *and* peripheral levels

tranquilization without barbiturate loginess

spasmolysis without belladonna-like side effects

for *duodenal ulcer • gastric ulcer • intestinal colic spastic and irritable colon • ileitis • esophageal spasm G. I. symptoms of anxiety states*

prescribe:
1 tablet t.i.d. at mealtime and 2 at bedtime.



"Milpath"

Miltown® + *anticholinergic*



Formula:

Miltown® (meprobamate) 400 mg. (2-methyl-2-*n*-propyl-1, 3-propanediol dicarbamate)
U. S. Patent 2,724,720
tridihexethyl iodide 25 mg.
(3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethiodide)

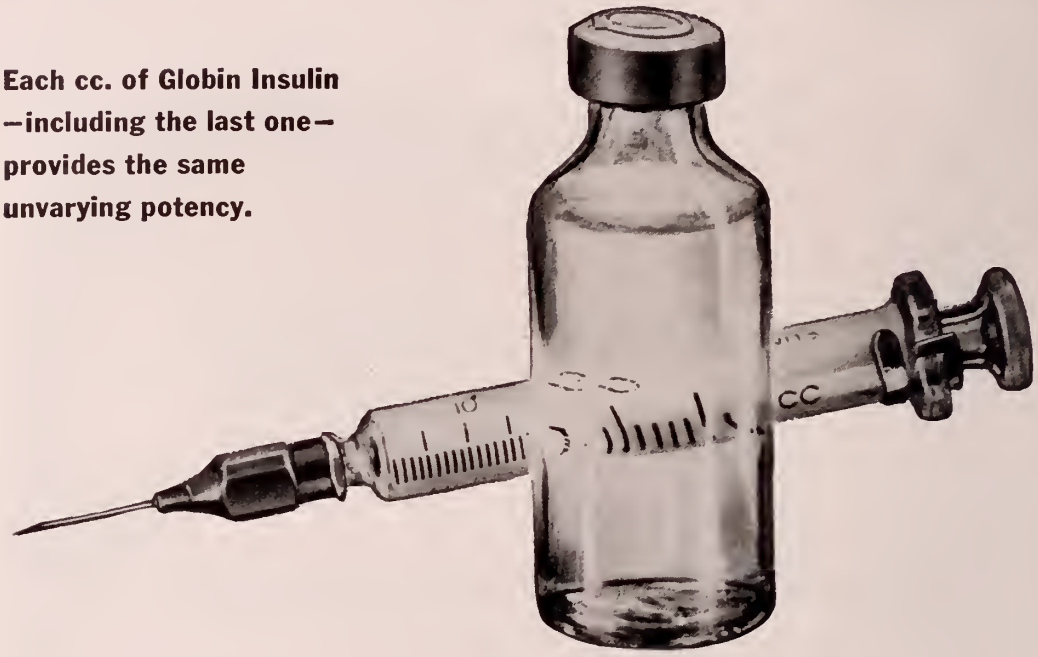
1. *Wolf & Wolff, Human Gastric Function*

Literature, samples, and personally imprinted peptic ulcer diet booklets on request.

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24-hour control for the majority of diabetics

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(Continued from page 542)

at which we had the honor of hearing Dr. William C. Roberts, of Panama City, President of the Florida Medical Association, as our speaker. For those of us who know and love that section of the state, it was a most pleasant visit and for those who had never been there it was an eye-opening experience.

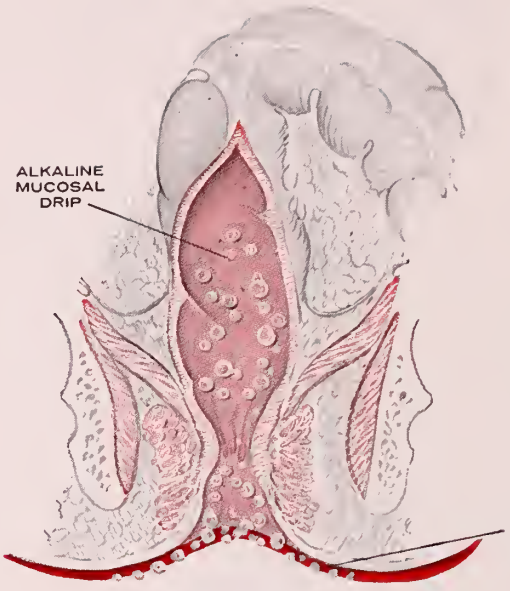
October 19th found the Auxiliary President and President-Elect, Mrs. Perry D. Melvin of Miami and Mrs. Lee Rogers Jr., of Rockledge, on their way to the Fall Conference of the Woman's Auxiliary to the American Medical Association in Chicago. There we spent three days in meetings and group discussions. This was one of the most valuable experiences a person interested in the work of the Auxiliary could have. Those of us who have had the inspiration and advantage of these Conferences will be forever grateful to the members of the Woman's Auxiliary to the Florida Medical Association, who assume the major portion of the cost of sending us there.

October 28th found the traveling pair in Panama City for the first of the District Meetings. These are also quite an experience but in an entirely different way. In Chicago, we were the neophytes. At the district meetings, we were the authorities who were supposed to know all the answers and be able to solve all the problems. If it were not for the former we could never attempt the latter.

Besides being Auxiliary authorities, you have the feeling of an actress playing one night stands. Drive like mad, starting early in the morning in order to make the next town, catch a quick bite to eat, freshen up, change clothes to make a more presentable appearance, then on to a meeting where you are to speak. Leave the meeting with a few minutes to rest and change clothes again, then on the social activities with the doctors and their wives, always under the kindly guiding wing of your hostess, the President of the local Auxiliary and her husband. Back to the motel for an all too short night's sleep, then up and away in the early hours and on the road to the next stop, feeling very smug if you get away before the doctors who are also making the circuit.

We enjoyed this opportunity of meeting and knowing the women all over the state, who might be missed at the convention or who could not go to the Conference because it is too far away.





Whatever the Rectal Pathology . . .
Whatever the Etiology . . .
Whatever Adjunctive Measures are Needed . . .

First neutralize proteolytic enzymes[1] and alkaline mucosal drip[2, 3, 4] associated with **PRURITUS ANI**

Provide immediate and prolonged relief in a high percentage of stubborn cases[5, 6] with the natural biochemical buffer —

HYDROLAMINS®

TOPICAL AMINO ACID PRURITUS THERAPY



BEFORE
Reddened, fissured and excoriated perianal skin, and whitening of the anal folds, accompanied by intense burning and itching of 3 years' duration.



AFTER
Same case after treatment with Hydrolamins. Note healing of the inflamed, fissured and excoriated areas and of the whitened anal folds.

Why Effective —

Hydrolamins-pH around 6—this enables it to buffer against the irritating alkaline mucosal secretions[2, 3, 4] with resultant rapid, prolonged, *soothing* neutralization.

Why Safe —

Biochemical in its composition and having a hydrogen-ion concentration in harmony with normal skin, Hydrolamins—unlike steroids or "caine" type anesthetics—avoids treatment dermatitis. Hydrolamins actually encourages wound healing.

Hydrolamins Indications Include —

Pruritus ani and vulvae . . . fissures . . . diaper rash . . . anal irritations and erythemas . . . pruritus due to pinworms . . . ileostomy and colostomy irritations . . .

1. Arthur, R. P., and Shelley, W. B.: A.M.A. Archives of Derm. 76:296 (Sept.) 1957. 2. Ehrlich, R.: Am. J. Proctol. 7:497 (Dec.) 1956. 3. Slocumb, L. H.: Am. J. Digest. Dis. 10:227 (June) 1943. 4. Bacon, H. E.: Anus-Rectum Sigmoid Colon, Diagnosis and Treatment, Philadelphia, J. B. Lippincott Co., 1949. 5. Bodkin, L. G., and Ferguson, E. A., Jr.: Am. J. Digest. Dis. 18:59 (Feb.) 1951. 6. McGivney, J.: Texas J. Med. 47:770 (Nov.) 1951.

SUPPLIED: 1 oz. and 2.5 oz. tubes.

LEWAL PHARMACEUTICAL COMPANY Chicago 14, Illinois

After four days of such constant companionship and feeling as though your companion has been your life long friend, your whole life is richer for the entire trip.

After the district meetings, it was back home for a short time, thankful for an understanding and sympathetic husband. Then there are plans for the Annual Convention of the Southern Medical Association and its Auxiliary. We will be official hostess for doctor's wives from all over the South. Everyone is expecting the same wonderful time they have always had in Florida at previous meetings of the Association and we feel proud as compliments for Florida hospitality are received.

We will especially welcome Mrs. Oscar W. Robinson of Paris, Texas, President of the Woman's Auxiliary to the Southern Medical Association, who said on taking office last year in Washington, that no one could ask for more than to have been "elected in my home state of Texas, installed in the Nation's capitol and to preside in paradise, Miami." We will also welcome Mrs. Paul C. Craig again and will be happy to have the opportunity of showing her another section of our home state.

Mrs. Perry D. Melvin

BOOKS RECEIVED

The Changing Patient-Doctor Relationship. By Martin G. Vorhaus, M.D., F.A.C.P. Pp. 310. Price, $3.95. New York, Horizon Press, 1957.

The result of 35 years of experience in treating men and women of every age, this book explores the need of both patient and doctor to arrive at a healthier understanding of each other. Clearly written, easy to understand, it is as interesting to a healthy person as to a patient troubled by his relationship with his doctor. "The needs of the patient can be satisfied," says the author. "The doctor has, to a very large degree, the means to satisfy these needs. This study is a means to an end: that is, to bring these two into the closest possible rapport with each other so that the doctor may fulfill his obligations to the patient." Five detailed case histories of absorbing interest are presented in a new way, through revealing conversations over long periods of time between patient and physician. Full of penetrating insights into people, and wisdom about the actual roots of the most frequent complaints and ailments, this book grows more meaningful and important with each reading.

William Harvey. *His Life and Times: His Discoveries: His Methods.* By Louis Chauvois. Pp. 271. Price, $7.50. New York, Philosophical Library, 1957.

The fame of William Harvey increases with the years. Even in this year marking the tercentenary of his death, the magnitude of the revolution in medical thought brought about by his discovery of the circulation of the blood is not sufficiently realized; it not only served as the foundation of physiology but also showed how research should be conducted. It should therefore be in-

(Continued on page 554)

when anxiety and tension "erupts" in the G. I. tract...

IN ILEITIS



PATHIBAMATE*

Meprobamate with PATHILON® Lederle

Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of ileitis — without fear of barbiturate loginess, hangover or habituation . . . *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

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New Chemotherapy

ARALEN® in RHEUMATOID ARTHRITIS

Extensive studies of rheumatoid arthritis and related collagen diseases—in this country and abroad—have shown the antimalarial Aralen phosphate to be highly effective and well tolerated in a large percentage of patients.

Clinical Results with Aralen in Rheumatoid Arthritis

Author	No. of Cases	Major Improvement	Minor Improvement	No Effect
Haydu[1]	28	22	5	1
Rinehart[2]	25	12	4	9
Freedman[3]	50	43	3	4
Bagnall[4]	108	77	12	19
Bruckner[5]	36	32	0	4
Cohen and Calkins[6]	22	17	3	2
Scherbel et al.[7]	25	9	8	8
Total	294	212 (72%)	35 (12%)	47 (16%)

- Success dependent upon persistent treatment
- Often of benefit where other agents have failed
- Remissions on therapy well maintained
- Remission of 3 to 12 months possible even if treatment is interrupted
- Tachyphylaxis not evident

GENERAL EFFECTS:

- Patient feels better
- Patient looks better
- Exercise tolerance increases
- Walking speed and hand grip improves

LABORATORY EFFECTS:

- E. S. R. may fall slowly

ANALGESICS AND STEROIDS:

- Requirements usually reduced or eliminated

JOINT EFFECTS:

- Pain and tenderness relieved
- Mobility increases
- Swellings diminish or disappear
- Muscle strength improves
- Rheumatic nodules may disappear
- Even severe or advanced deformit may improve
- *Active* inflammatory process usua subsides
- Joint effusion may diminish

DOSAGE:

Aralen is cumulative in action and requires four to twelve weeks of administration before therapeutic e become apparent.

Latest information indicates that an initial dose of 250 mg. of Aralen phosphate is pref to the higher doses sometimes recommende However, if side effects appear, withdraw Aralen for several days until they subside. Reinstate treatment with 125 mg. daily and, if well tolerated, increase to 250 The usual maintenance dose is 250 mg. dail

New Chemotherapy

INDICATIONS:

- Rheumatoid arthritis, acute or chronic —with or without adjunctive therapy.
- Spondylitis
- Arthritis associated with lupus erythematosus or psoriasis

THEORY OF ACTION:

Aralen appears to suppress or induce remission of rheumatoid inflammatory processes by inhibiting adenosinetriphosphatase.

HOW SUPPLIED:

Aralen phosphate: 250 mg. tablets in bottles of 100 and 1000.
125 mg. tablets in bottles of 100.

Tolerance:

Aralen is usually well tolerated. Toxic effects are usually mild and to date have been transitory in nature, disappearing completely either on continuance or cessation of therapy or on reduction in dosage.

Gastrointestinal disturbances (e.g. nausea, rarely vomiting, diarrhea, abdominal cramps, anorexia) are frequent manifestations of intolerance. Temporary blurring of vision (due to interference with accommodation) is also relatively frequent.

Pleomorphic skin eruptions (e.g. lichenoid, maculopapular, purpuric), although generally mild, may preclude the use of an optimum dosage schedule. If a skin reaction persists on a reduced dosage schedule, or recurs after reinstitution of treatment with gradually increasing doses, discontinue Aralen till the lesion again disappears and consider resuming treatment with Plaquenil® (brand of hydroxychloroquine).

Less frequently transitory vertigo, headache, lassitude, or neurological disturbances, such as nervousness, irritability, emotional change, and nightmares have been reported. Instances of unexplained slight gradual weight loss as the patient's general health and arthritic condition improved have been mentioned. Occasional instances of bleaching (depigmentation) of the hair have been described.

Although an occasional instance of leukopenia, with normal differential count, has been reported (WBC about 3000), it has not proved troublesome because it has always been reversible on discontinuance, or diminution of the dose. Even spontaneous reversal may occur while full dosage is maintained.

Caution:

Aralen is known to concentrate in the liver and, although hepatic damage has never been reported, the drug should be used with caution in the presence of liver disease. In the presence of severe gastrointestinal, neurological, or blood disorders, the drug should be used with caution or not at all. If such disorders occur during the course of therapy, the drug should be discontinued. Concomitant use of gold or phenylbutazone with Aralen should be avoided because of the tendency of these agents to produce drug dermatitis.

Clinical Comments:

Of fifty patients receiving Aralen therapy, "43 have become really well; that is, they have no stiffness, and any pain that occurs can reasonably be attributed to use of joints affected by secondary degenerative changes. They have no evidence of joint inflammation, but may have a raised erythrocyte sedimentation rate. They have little or no need for analgesics." *Freedman*[3]

"One hundred and twenty-five private patients have been carefully followed clinically and haematologically while receiving well over 200 patient-years of chloroquine [Aralen] therapy. The results are considered good in 70%, one-half of these cases being in remission. Improved work performance, sedimentation rate, and hemoglobin levels paralleled the major objective gain in this 70%. 90% of them remained on chloroquine [Aralen] therapy, half for more than two years. Classical peripheral rheumatoid arthritis, spondylitis, arthritis of juvenile onset, and rheumatoid disease with psoriasis, all appeared to respond about equally well.

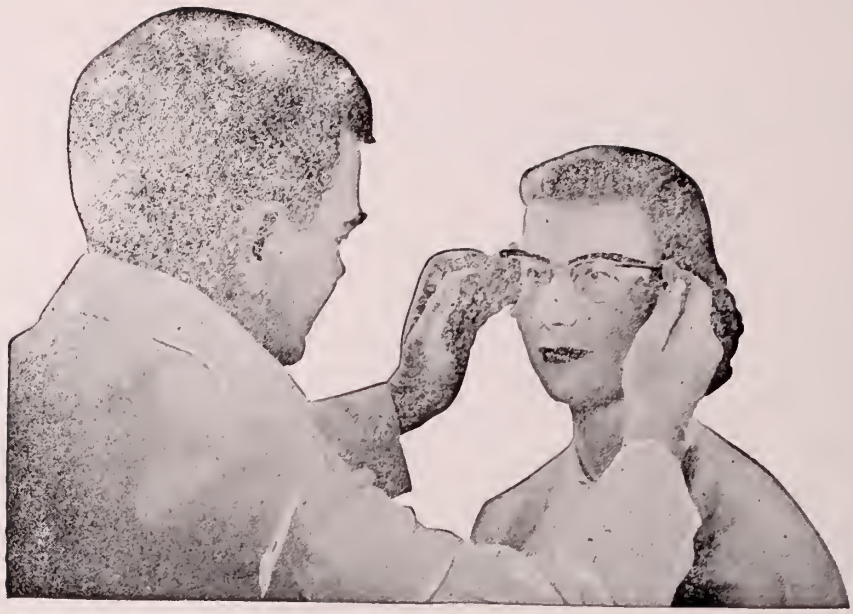
"It is suggested that chloroquine comes closer to the ideal for long-term, safe, control of rheumatoid disease than any other agent now available." *Bagnall*[4]

"Out of the 36 rheumatoid arthritis cases we treated . . . favorable results were obtained in 32 cases. *Bruckner et al.*[5]

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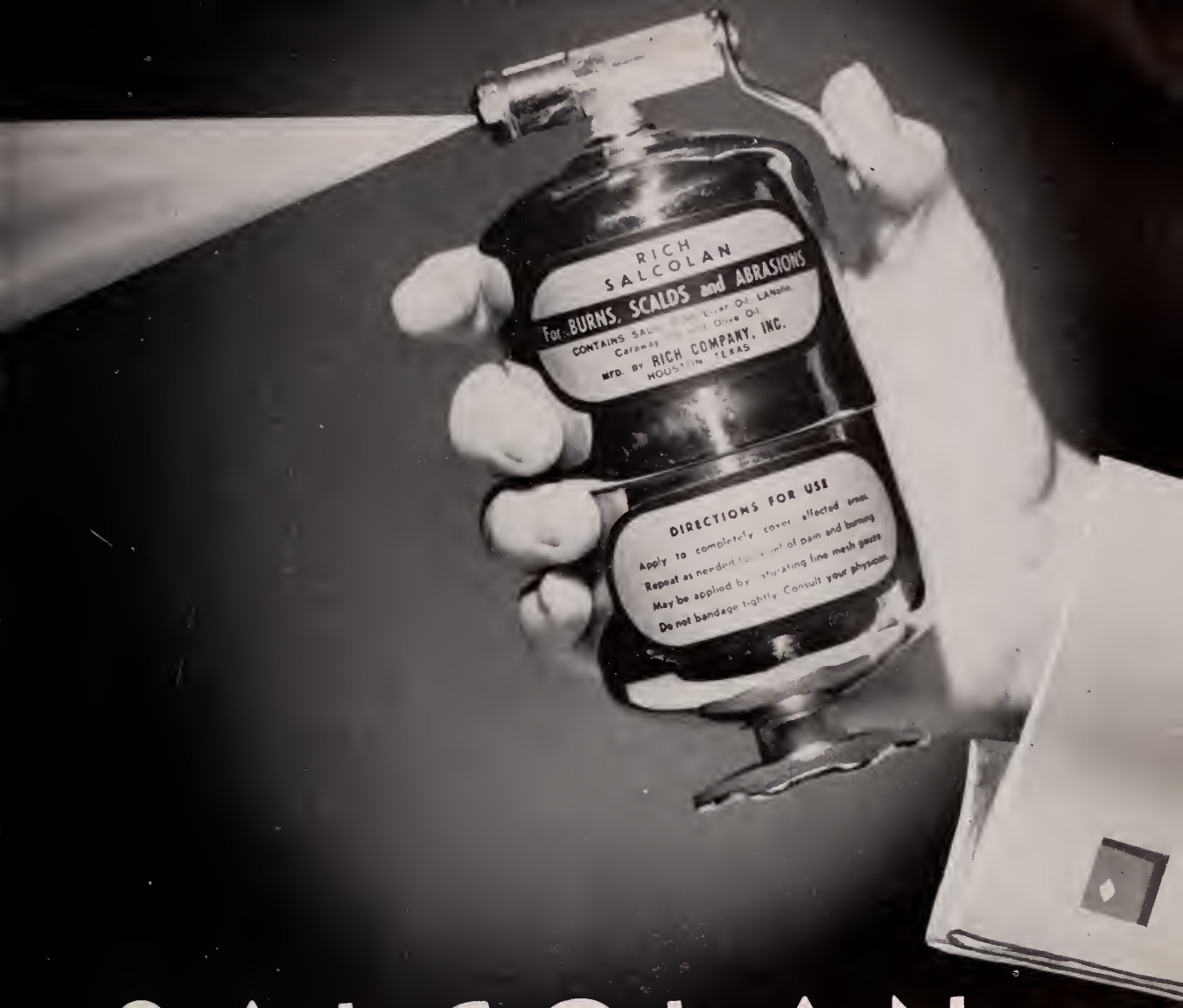
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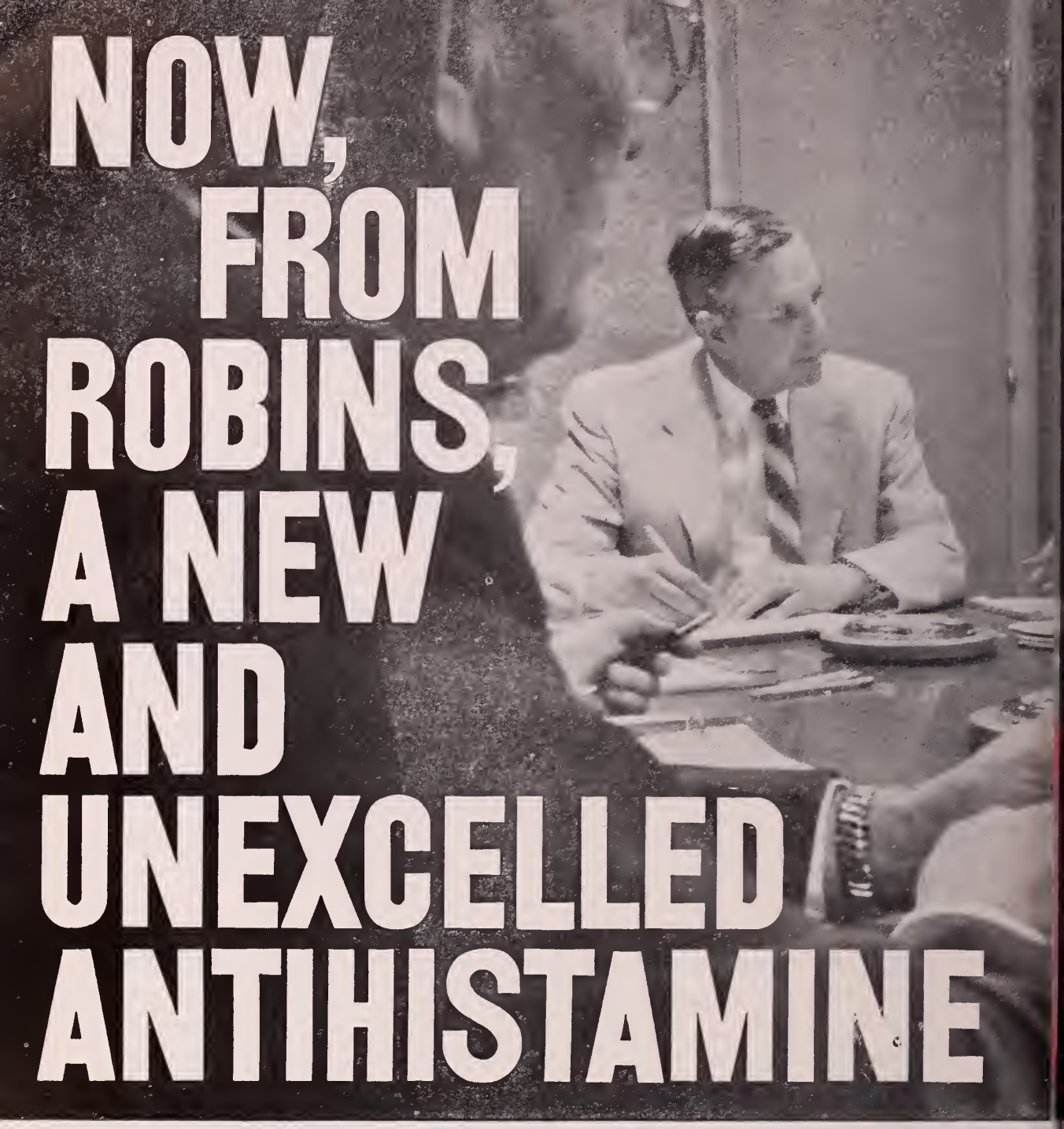
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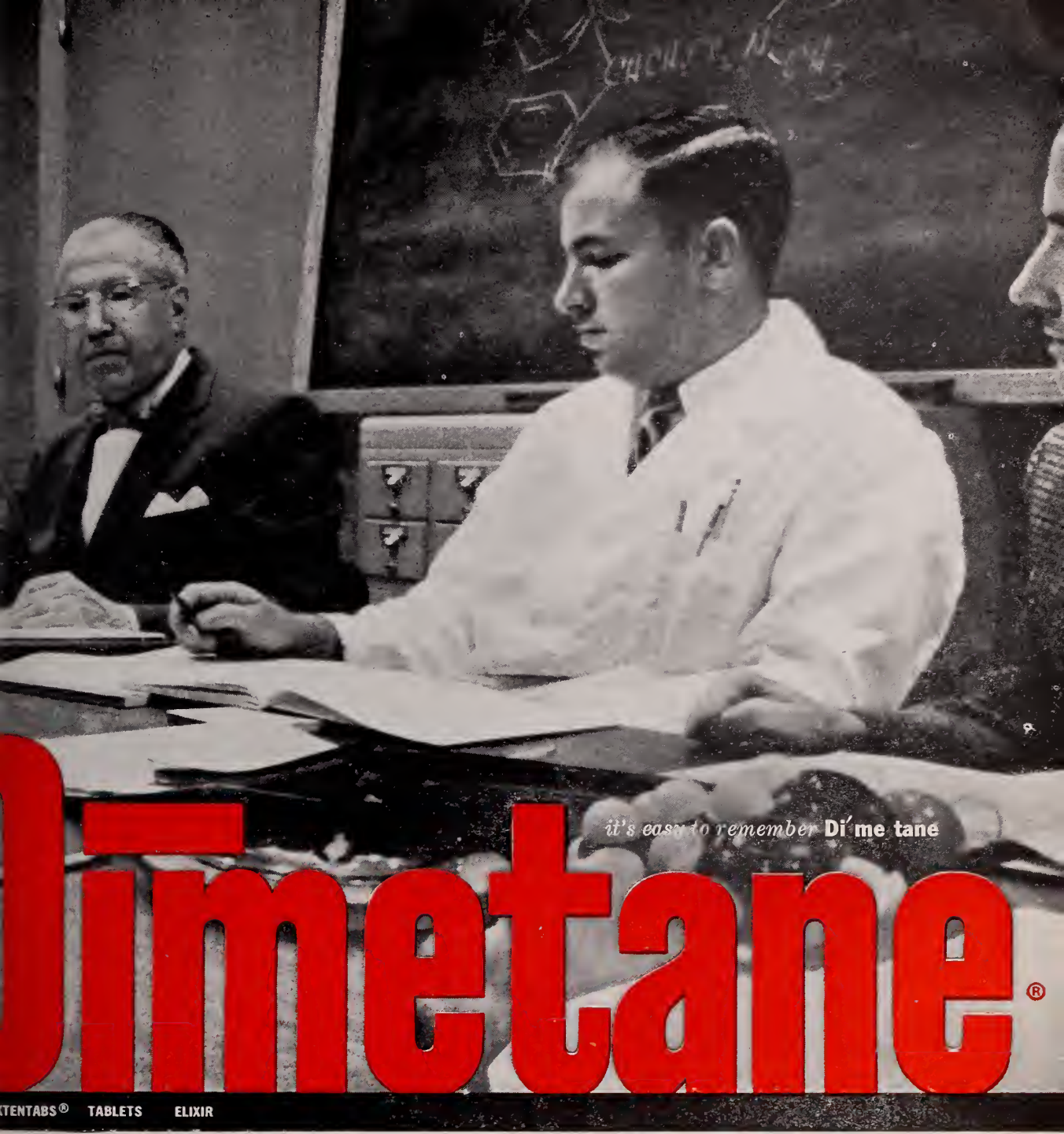
why Dimetane is the best reason yet for you to re-examine the antihistamine you're now using » *Milligram for milligram*

DIMETANE potency is unexcelled. DIMETANE has a therapeutic index unrivaled by other antihistamine—a relative safety unexceeded by any other antihistamine. DIMETANE, even in very low dosage, has been effective when other antihistamines have failed. Drowsiness, other side effects have been at the very minimum.

Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Drowsine
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsine
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) Dizzy (1)

» unexcelled antihistaminic action

From the preliminary **Dimetane Extentabs** studies of three investigators. Further clinical investigations will be reported as com



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XTENTABS® TABLETS ELIXIR

DIMETANE IS PARABROMDYLAMINE MALEATE – EXTENTABS 12 MG., TABLETS 4 MG., ELIXIR 2 MG. PER 5 CC.

anket of allergic protection, covering 10-12 rs—with just one Dimetane Extentab » *DIMETANE ntabs protect patient for 10-12 hours on one tablet.*



Periods of stress can be easily handled with supplementary DIMETANE Tablets or Elixir to obtain maximum coverage.

Dosage:

Adults—One or two 4-mg. tabs. or two to four teaspoonfuls Elixir, three or four times daily. One Extentab q.8-12 h. or twice daily.

Children over 6—One tab. or two teaspoonfuls Elixir t.i.d. or q.i.d., or one Extentab q.12h.

Children 3-6—½ tab. or one teaspoonful Elixir t.i.d.

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(Continued from page 547)

cumbent on all medical students and practitioners to know as much as can be known of the life and times, the discoveries and methods of this great physician. In this book, Dr. Chauvois, a distinguished French physician and medical historian, has provided a most original and scholarly life of Harvey, giving first an account of his life and relations with his contemporaries. He then re-examines the Latin texts and suggests that some current interpretations of Harvey's teaching are seriously at fault. Dr. Chauvois maintains that Harvey's line of thought, if properly understood and pursued in the light of modern knowledge, leads to some modifications of practical importance in the interpretation of the circulation of the blood.

In the Foreword, Sir Zachary Cope writes that Dr. Chauvois has produced a lifelike portrait of Harvey the man and Harvey the scientist, adding, "He writes with wit and charm, and with an imagination which adds piquancy to the narrative while not going beyond the probabilities of the case. . . . This very readable book with its up-to-date information and review of Harvey's life and work comes at an opportune moment when all the world is about to celebrate the tercentenary of his death; it deserves and should obtain wide recognition and appreciation."

Fluid and Electrolytes in Practice. By Harry Statland, M.D. Ed. 2. Pp. 229. Price, $6.00. Philadelphia, J. B. Lippincott Company, 1957.

This book provides a simply written and practical foundation in the fundamentals of fluid therapy and electrolyte balance for the practicing physician. The author has handled his subject matter in such a way that no matter how far removed the reader may be from his studies in the basic sciences he will still find the text completely understandable and its content easy to assimilate. Part One presents the basic principles of fluid movements and the major abnormalities of volume, concentration and acid base balance. In this section the management of the surgical patient is stressed. In Part Two the application to management of special diseases is discussed more fully.

In this second edition extensive revisions have been made throughout. The section on potassium metabolism and renal excretion of potassium has been largely rewritten. The description of electrocardiographic changes of electrolyte imbalance has been amplified, and a discussion of salicylism added. The role of ADH in the post-traumatic period is stressed.

Alcoholism: *A Treatment Guide for General Practitioners.* By Donald W. Hewitt, M.D. Pp. 112. Price, $3.00. Philadelphia, Lea & Febiger, 1957.

The author, who is chief medical advisor at the Charity Alcoholic Rehabilitation Center in Los Angeles, presents a clear, comprehensive analysis of the deep-seated medical, sociologic and psychologic problems that confront the alcoholic patient in this first book of its kind intended primarily for the general practitioner. It is the family physician who almost always sees the alcoholic patient first, and in this book he will find a valuable aid to help him meet the widespread need for specific management, treatment and follow-up therapy of alcoholism as it is encountered on all social levels. In addition to being an explicit treatment guide for general practitioners, the book explains the nature of the problem and shows psychiatrists, psychologists, ministers, social workers, nurses, judges, probation and parole officers, teachers, lawyers, personnel managers and others who have contact with victims of alcoholism how to cooperate with the general practitioner in reaching an effective solution. The work is based on the successful results obtained from treating an average of 100 alcoholic patients a month in the largest alcoholic rehabilitation cen-

when anxiety and tension "erupts" in the G. I. tract...

in spastic and irritable colon



PATHIBAMATE*

Meprobamate with PATHILON® Lederle

Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer...helps control the "emotional overlay" of spastic and irritable colon—without fear of barbiturate loginess, hangover or habituation ...*with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

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for these **25** *adult indications:*

TENSION SENILE ANXIETY MENOPAUSAL SYNDROME ANXIETY PREMENSTRUAL TENSION
PHOBIA HYPOCHONDRIASIS TICS FUNCTIONAL G. I. DISORDERS PRE-OPERATIVE ANXIETY
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PEACE OF MIND ATARAX® (BRAND OF HYDROXYZINE) *Tablets-Syrup*

Supplied: In tiny 10 mg. (orange) and 25 mg. (green) tablets. Also now available in 100 mg. tablets. Bottles of 100. ATARAX Syrup, 10 mg. per tsp., in pint bottles. Prescription only.

10 *mg. (t.i.d.)*

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ANXIETY TICS
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NOW: SAFE... QUICK
ATARAX® PARENTERAL SOLUTION



when Peace of Mind can't wait

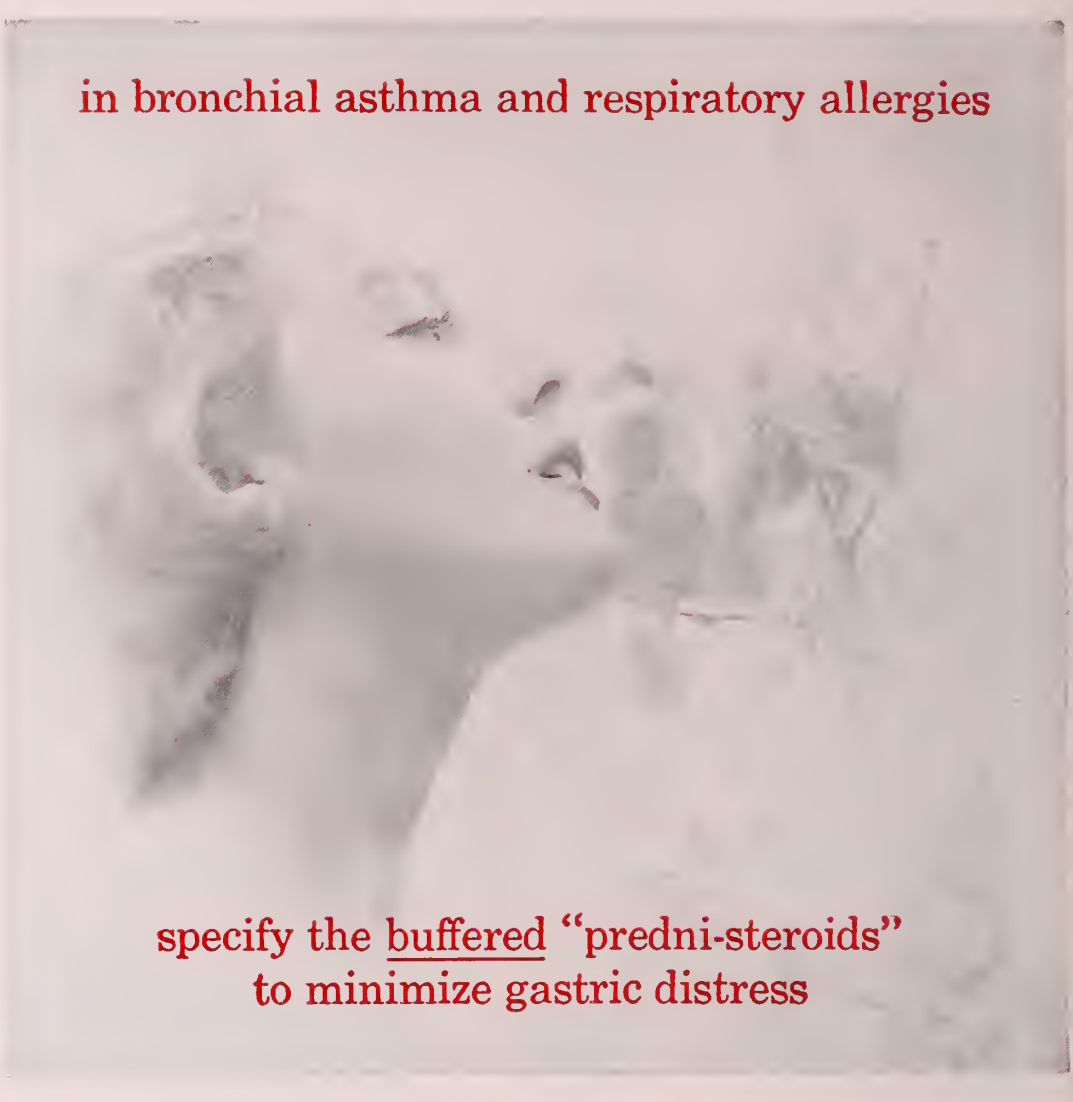
In daily practice: always have it handy
- to calm the acutely disturbed or hysterical patient
- to rehabilitate the alcoholic

In hospitals: use it routinely
- to make overwrought patients manageable without loss of alertness
- to allay anxiety and control vomiting before and after surgery and childbirth

Supplied: 10 cc. multiple-dose vials. The adult dosage is 25 mg. to 50 mg. (1-2 cc.) intramuscularly, 3 to 4 times daily, at 4 hour intervals. The moderated dosage level for children under 12, when given intramuscularly, has not yet been established, and the oral dosage should be used.

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to minimize gastric distress

combined steroid-antacid therapy . . .

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'Co-Deltra' or 'Co-Hydeltra' provides all the benefits of "predni-steroid" therapy and minimizes the likelihood of gastric distress which might otherwise impede therapy. They provide easier breathing—and smoother control—in bronchial asthma or stubborn respiratory allergies.

SUPPLIED: Multiple Compressed Tablets 'Co-Deltra' or 'Co-Hydeltra' in bottles of 30, 100, and 500.

Multiple Compressed Tablets



2.5 mg. or 5.0 mg. of prednisone or prednisolone, plus 300 mg. of dried aluminum hydroxide gel and 50 mg. of magnesium trisilicate.

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ter of its kind in the western United States. Dr. Hewitt establishes a new understanding and sympathy on the part of the physician, and stresses the vital need to secure the confidence and cooperation of his alcoholic patient's family and friends. The necessary steps and how to take them are outlined clearly. Antabuse, Thorazine, Sparine and other currently accepted drugs are included in the sections on therapy.

Signs and Symptoms: *Applied Pathologic Physiology and Clinical Interpretation.* Edited by Cyril Mitchell MacBryde, A.B., M.D., F.A.C.P. Ed. 3. Pp. 973. Illus. 191. Philadelphia, J. B. Lippincott Company, 1957.

This third edition of a unique aid in the practice of medicine offers a ready source of helpful information of great practical value. It approaches diagnosis as any physician must—through analysis and interpretation of presenting signs and symptoms. In each chapter a major symptom or sign is discussed, the mechanism of its production clarified by the light thrown upon it by anatomy, physiology, pathology, chemistry, or psychology, its correlation with other symptoms and physical and laboratory findings described. The introductory chapter is an able presentation of clinical relations between doctor and patient and subsequent patient management. The chapter on Pain is an especially valuable one since pain is the commonest symptom that brings the patient to the physician and no matter how distressing other symptoms may be, it is pain that is the prime consideration of the patient.

Every effort has been made by thorough revision to improve and bring up to date all chapters in the book. New chapters have been added on Growth and Sex Development, Generalized Vasospasm and Arterial Hypertension, and Lymphadenopathy and Diseases of the Lymphatic System. Each chapter concludes with a concise summary of its content.

Surgery in World War II. Orthopedic Surgery in the Mediterranean Theater of Operations. Editor in Chief, Colonel John Boyd Coates, Jr., MC; Editor for Orthopedic Surgery, Mather Cleveland, M. D.; Associate Editor, Elizabeth M. McFetridge, M. A. By Oscar P. Hampton, Jr., M. D., F. A. C. S., Colonel, MC, USAR. Pp. 368. Washington, D. C., Office of the Surgeon General, Department of the Army, 1957.

This most recently published volume of the official history of the Medical Department, United States Army in World War II, is the second of the three planned volumes on orthopedic surgery. The combat experience in the Mediterranean area lasted from November 1942 until May 1945. During this period of approximately 30 months, battle casualties were treated by the officers of the United States Army Medical Corps in the various echelons of the theater. The medical officers in the Mediterranean theater thus had a much longer experience in the treatment of battle casualties than the medical officers in the European theater and had correspondingly greater opportunities to gather data for the evaluation of their technics of treatment. Developing by a process of evolution, orthopedic surgery in this area served as a testing ground for the principles and technics which were applied with such success in the later campaigns in this theater and by which these injuries were treated in the European Theater of Operations in 1944 and 1945.

Colonel Hampton, consultant in orthopedic surgery for the theater, was indefatigable in spreading throughout the hospitals of the theater the principles upon which the surgery of wounds of the bones and joints is based. During the war and immediately thereafter, he, with the assistance of many of his colleagues, collected invaluable data on military orthopedic surgery. The studies which were the result of these investigations and which are presented in this volume form an unusually complete and comprehensive analysis of orthopedic surgery in an overseas theater. The book should be of great interest to all medical officers, including those who later served in Korea, and should serve as a source of information and inspiration to medical students who will almost inevitably serve for a time in the medical service of the Armed Forces.

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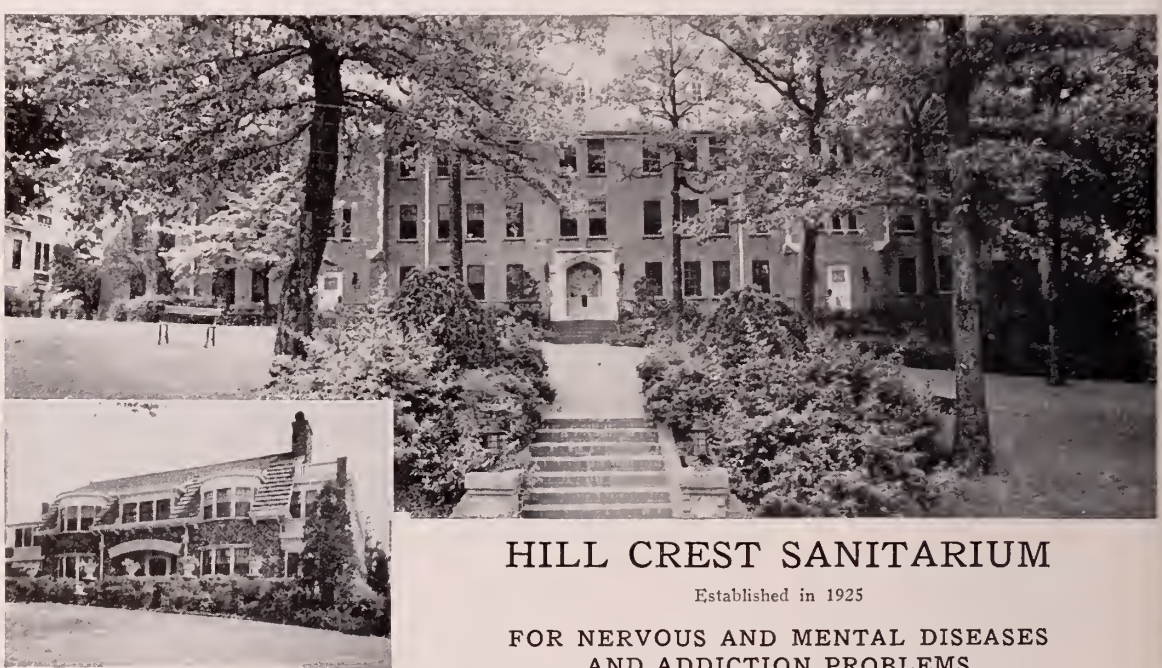


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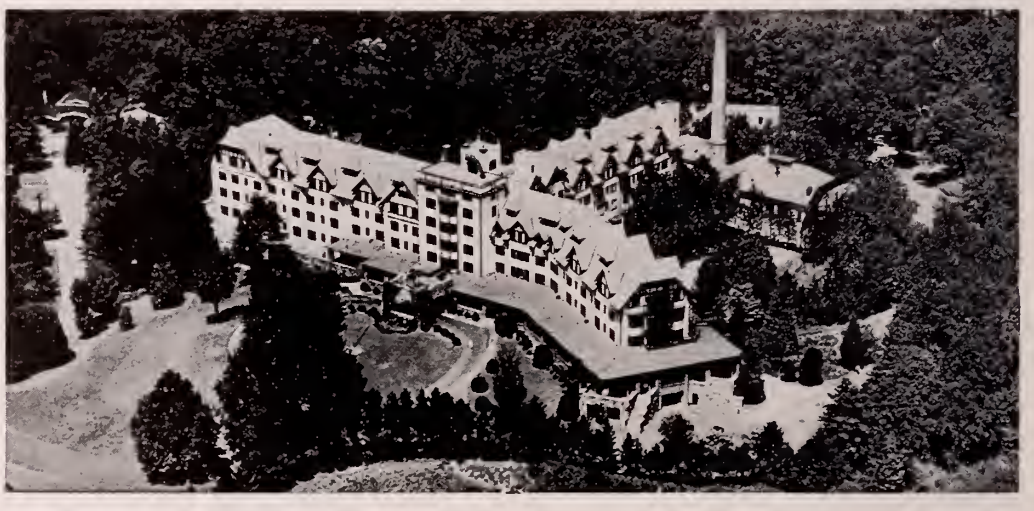
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**Bradford, Gilchrist, Union*				
Bay	John J. Benton, Panama City	Lloyd B. Harrison Jr., Panama City	1st Tues.	29
Brevard	Myron L. Habegger, Rockledge	Louis C. Jensen Jr., Rockledge	2nd Tues.	52
Broward	Walter J. Glenn Jr., Fort Lauderdale	Garland M. Johnson, Fort Lauderdale	4th Tues.	174
Collier	James A. Craig, Naples	Ethel H. Trygstad, Naples	3rd Wed.	9
Columbia	Thomas H. Bates, Lake City	Laurie J. Arnold Jr., Lake City	1st Mon.	11
**Baker*				
Dade	Walter W. Sackett Jr., Miami	Vincent P. Corso, Miami	1st Tues.	820
DeSoto-Hardee-Highlands-Glades	Godfrey L. Beaumont, Sebring	Theodore W. Weeks Jr., Sebring	1st Tues.	28
Duval	Leo M. Wachtel, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	332
**Clay*				
Escambia	Paul F. Baranco, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	111
Franklin-Gulf	Photis J. Nichols, Apalachicola	William F. Wager, Port St. Joe	Last Wed.	6
Hillsborough	Madison R. Pope, Plant City	James A. Winslow Jr., Tampa	1st Tues.	225
Indian River	Walter W. McCorkle, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	10
Jackson-Calhoun	William W. Richardson, Graceville	Francis M. Watson, Marianna	Quarterly	15
Lake	Fred A. Vincenti, Mount Dora	J. Basil Hall, Tavares	1st Wed.	31
**Sumter*				
Lee-Charlotte-Hendry	James L. Bradley, Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	39
Leon-Gadsden-Liberty-Wakulla-Jefferson	George S. Palmer, Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	76
Madison	Julian M. DuRant, Madison	A. Franklin Harrison, Madison		8
Manatee	Joseph A. Gibson, Bradenton	Warren G. Darty, Palmetto	2nd Tues.	31
Marion	John D. Lindner, Ocala	Robert L. Gibson, Ocala	3rd Tues.	36
**Levy*				
Monroe	Robert W. Reid, Key West	Joseph J. Scarlet, Key West	1st Thurs.	13
Nassau	Benj. F. Dickens, Fernandina Beach	David D. Bennett Jr., Callahan	1st Thurs.	9
Orange	Frank J. Pyle, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	220
**Osceola*				
Palm Beach	Edward W. Wood, Lake Worth	Robert Y. Wheelihan, Riviera Beach	4th Mon.	159
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs	19
Pinellas	Percy H. Guinand, Clearwater	Whitman C. McConnell, St. Petersburg	1st Mon.	260
Polk	John P. Tomlinson Jr., Lake Wales	Charles Larsen Jr., Lakeland	2nd Wed.	115
Putnam	Alfred P. Peretti, Palatka	Norman B. Edgerton, Palatka	2nd Tues.	11
St. Johns	Milton Segal, St. Augustine	William J. Gibson, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	John M. Gunsolus, Stuart	Adrian M. Sample, Fort Pierce	3rd Thurs	28
Sarasota	Samuel E. Kaplan, Venice	James E. Kicklighter, Sarasota	2nd Tues.	69
Seminole	Gordon D. Stanley, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee-Hamilton-Lafayette	Hiram B. Curry, Jasper	William P. Blackmon, Jasper	1st. Sat.	11
Taylor	Charles R. Wiley, Perry	Ralph J. Greene, Perry	Last Fri.	6
**Dixie*				
Volusia	Arthur Schwartz, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	90
**Flagler*				
Walton-Okaloosa-Santa Rosa	Ralph B. Spires, DeFuniak Springs	Howard A. Parker, Valparaiso	3rd Tues.	28
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay		4

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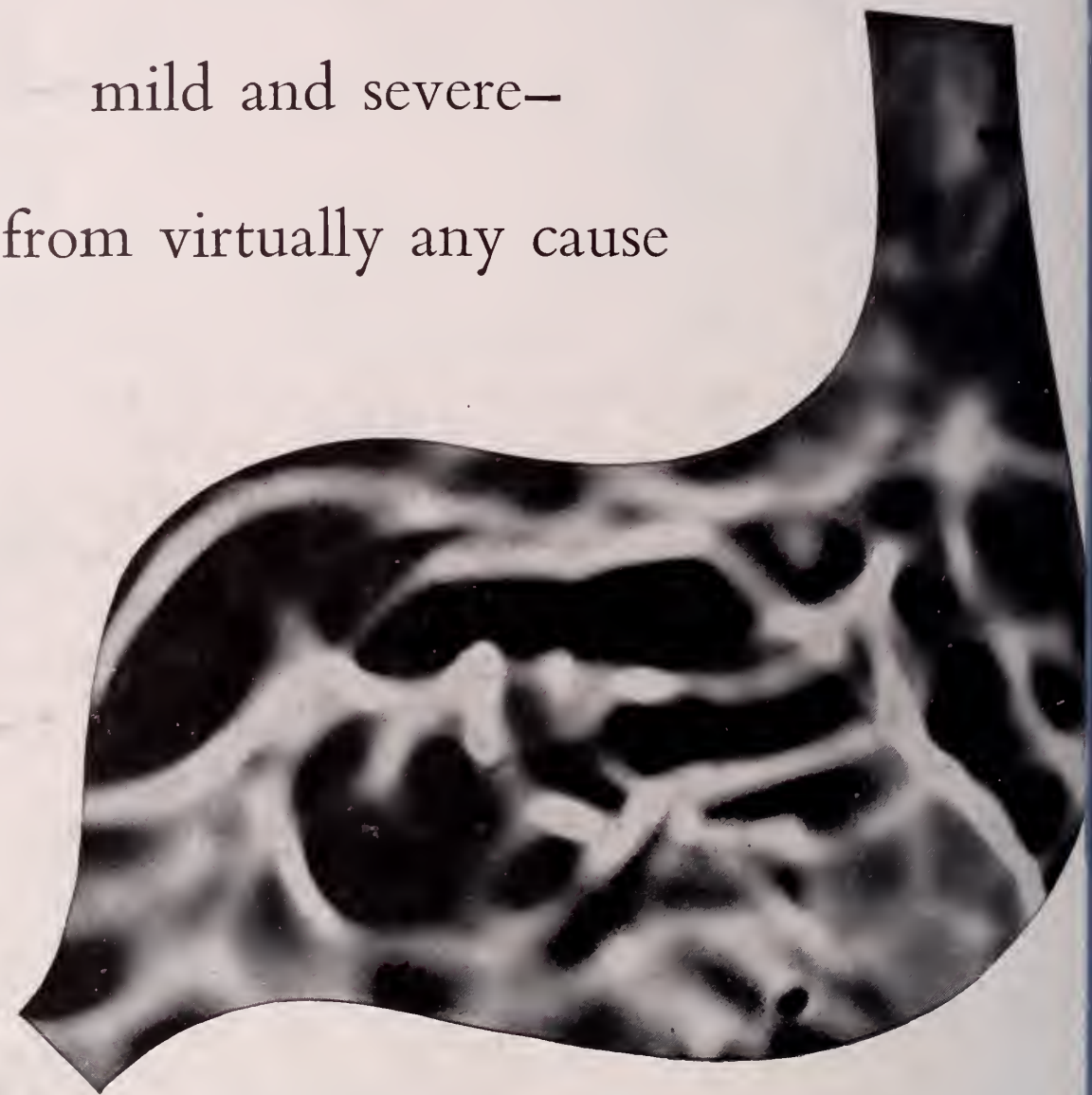


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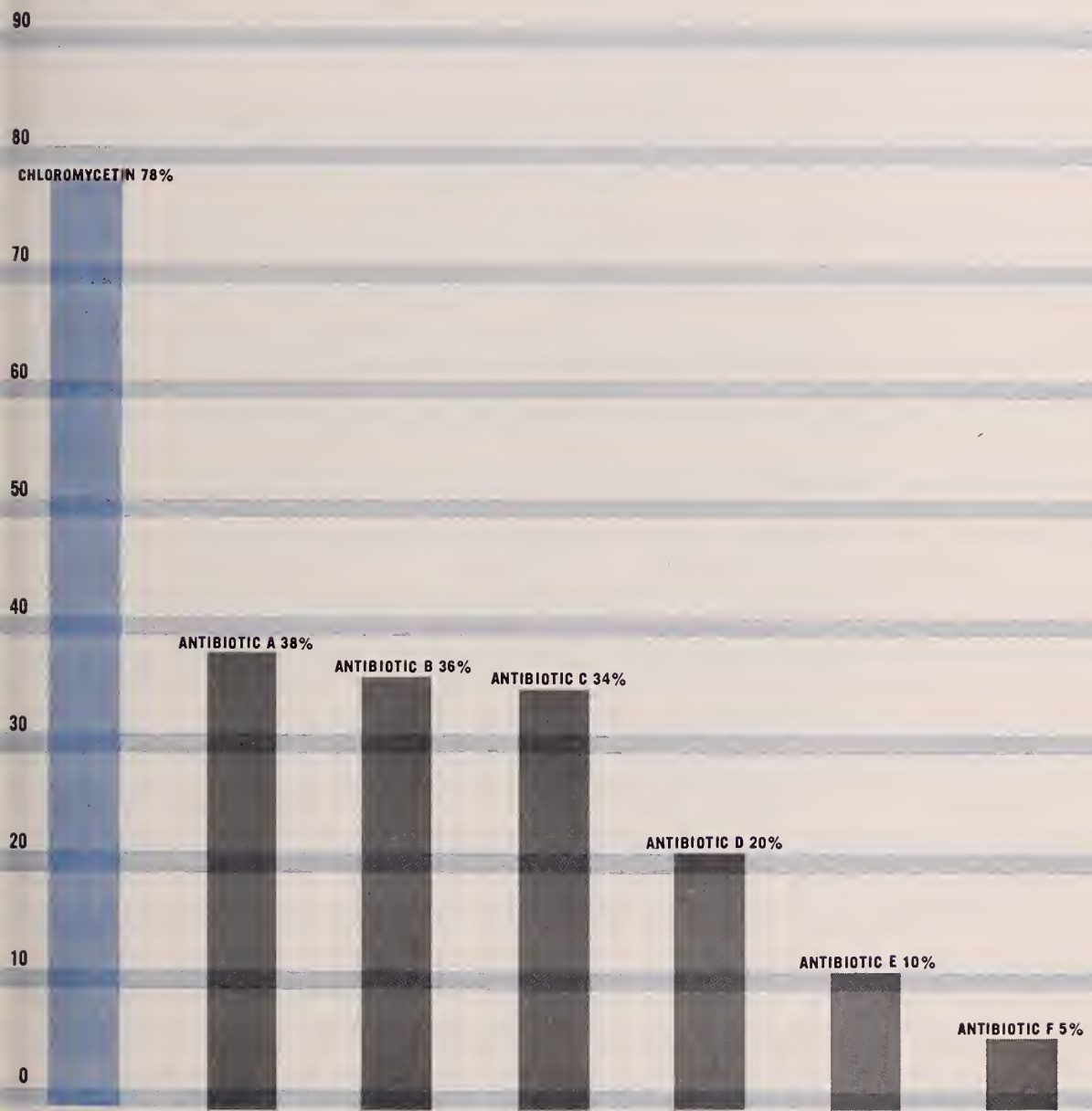
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*This graph is adapted from Waisbren and Strelitzer.[15] It represents *in vitro* data obtained with clinical material isolated between the years 1951 and 1956. Inhibitory concentrations, ranging from 3 to 25 mcg. per ml., were selected on the basis of usual clinical sensitivity.

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924



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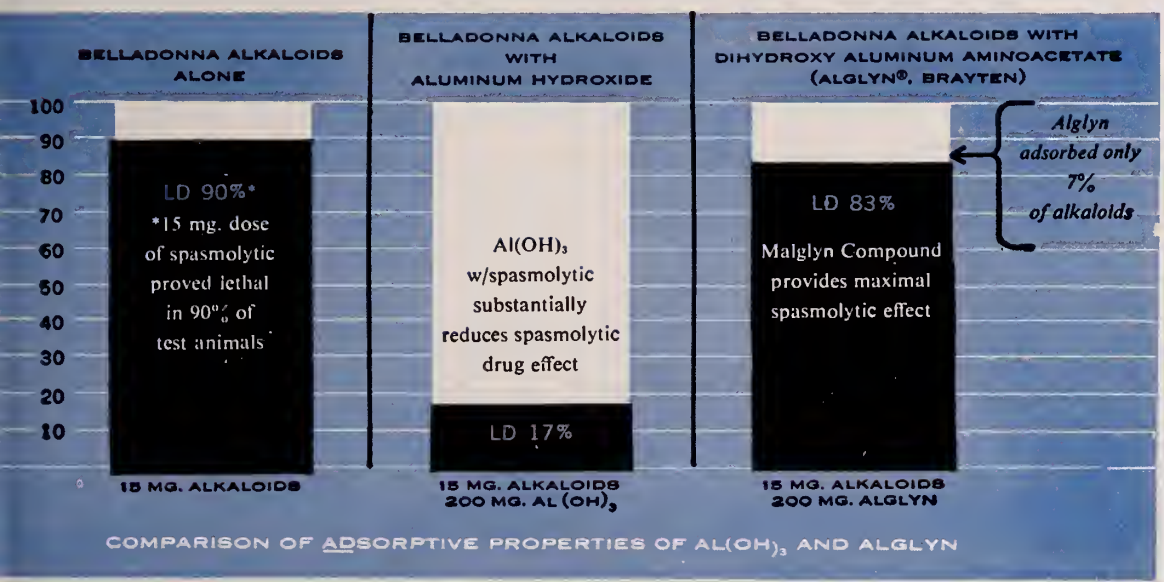
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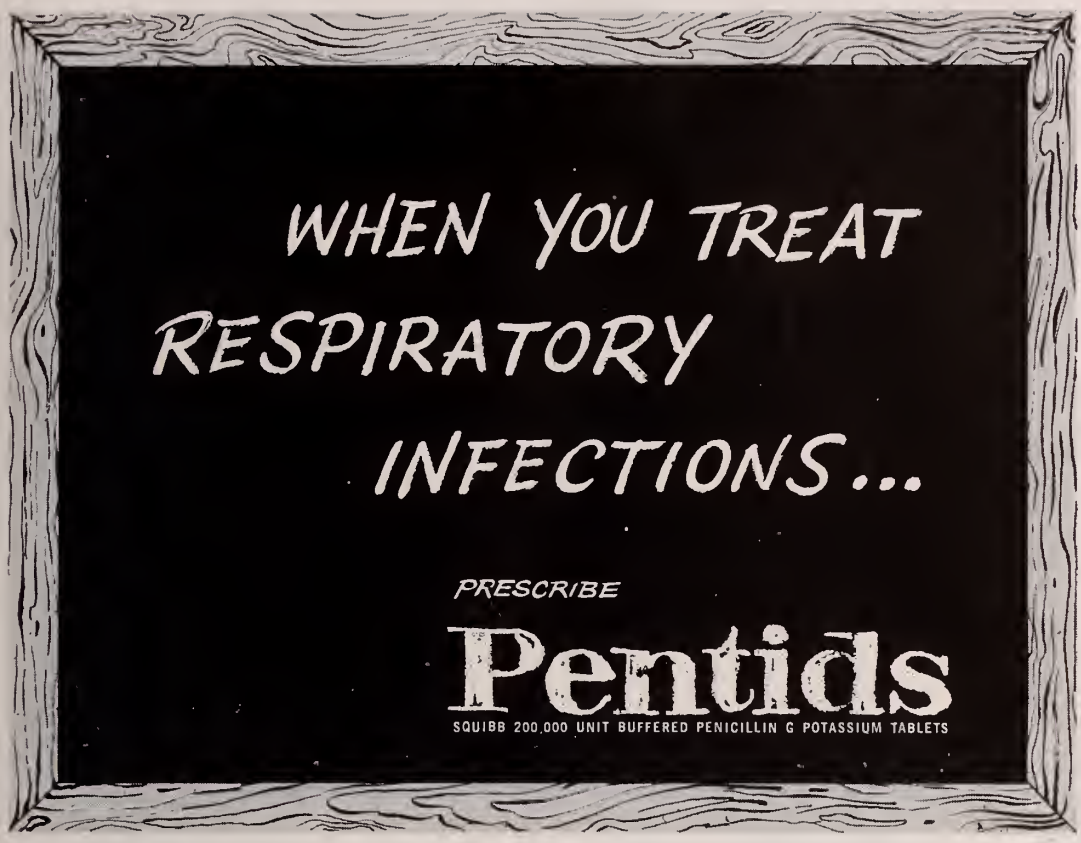
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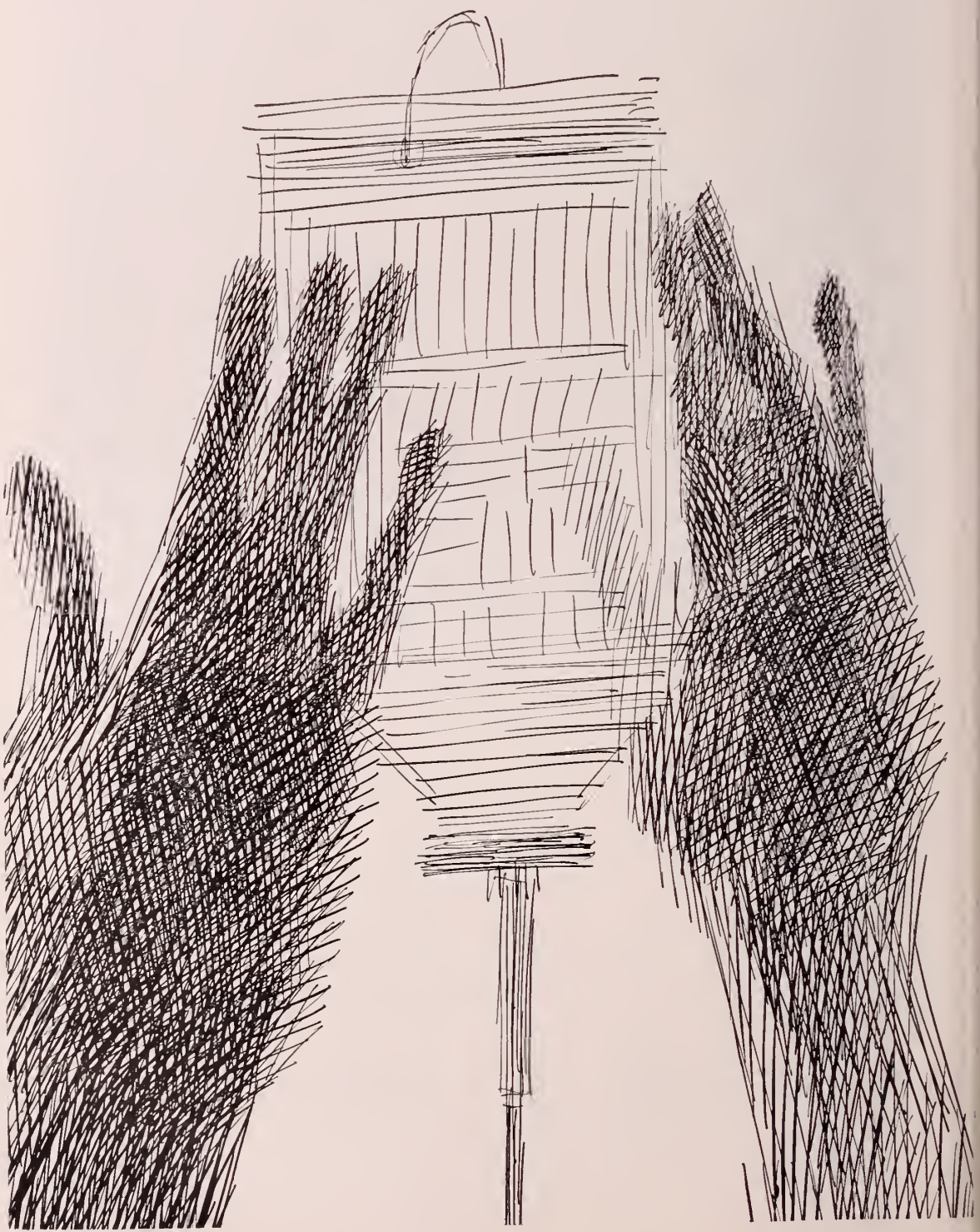
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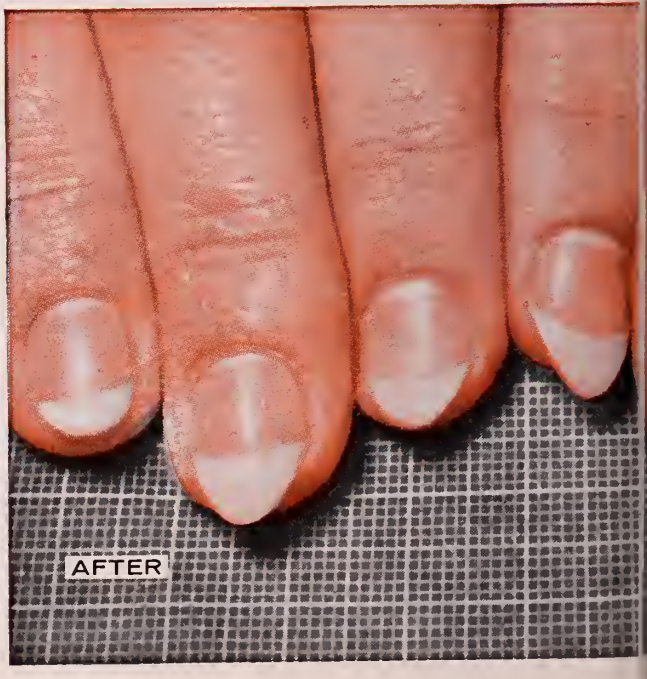
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KNOX PROTEIN PREVIEWS



TWO NEW
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Evidence continues to accumulate verifying the effectiveness of Gelatine in the treatment of brittle fingernails. Investigators report that the nails show objective evidence of improvement.[1,2,3,4] Furthermore, patients often volunteer that their nails "feel stronger," "look smoother," and "I can pick up things without them hurting."[1] Evidently the subjective sensations associated with improvement are nearly as important to some patients as the positive physical change in the nails' appearance.

Improvement Noted in 81% of Patients

See the chart below for a summary of the effect of Knox Gelatine in brittle fingernails as observed in all published reports. Photographic evidence of improvement, much of it in color taken before and during treatment, is available for most of the patients.[1,2,3] Please note, however, that where Gelatine was used in the treatment of pathological conditions associated with brittle fingernails only in psoriasis did the data show definite improvement.[1,3,4]

Response to Gelatine in Brittle Fingernails

References	Dosage	Duration of treatment	No. patients w/ brittle nails	No. patients improved	No. patients w/ brittle nails and other pathology	No. patients improved
1. Rosenberg, S., Oster, K. A., Kallos, A. and Burroughs, W.: *A.M.A. Arch. Dermat* 76:330, (September) 1957	7 Gm./ day	3 months	**50**	**43** (86%)	**32**[a]	**9**
2. Schwimmer, M. and Mulinos, M.G. *Antibiot. Med. & Clin. Therapy* 4:403, (July) 1957	7.5 Gm./ day	11-16 weeks	**18**	**15** (83%)		
3. Rosenberg, S. and Oster, K. A.: *Conn. State Med. J* 19:171, (March) 1955	7 to 21 Gm./day	15 weeks	**36**	**26**[b] (72%)		
4. Tyson, T. L.: *J. Invest. Dermat* 14:323, (May) 1950	7 Gm./day	13 weeks	**12**	**10**[c] (83%)		
Totals	7-21 Gm.	11-16 weeks	**116**	**94** (81%)	**32**	**9** (28%)

a. Gelatine improved psoriatic nails in 5 out of 12 cases. In onychomycosis and other pathological conditions of the nail it was of no appreciable help.

b. Of the failures, 2 had congenital disease of the nails, 3 were diabetics and 3 took the medication for less than one month.

c. One patient with psoriasis and arthritis and one patient with psoriasiform nail changes showed improvement in 2 and 3 months respectively.

RITTLE FINGERNAILS

Important Note

The pharmacodynamic effects of Gelatine are manifested through its high Specific Dynamic Action, and therefore, depend upon adequate and prolonged intake. All published clinical research has been conducted using 7 to 21 grams (1-3 envelopes) of Knox Gelatine per day for the three to four months that are required for complete regrowth of the nails. Smaller dosage would induce a lesser specific dynamic action and thus prove ineffectual in correcting the brittle nail defects. More detailed information on brittle fingernails and reprints of the two more recent clinical reports are available on request. Please use the attached coupon.

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*T. M.

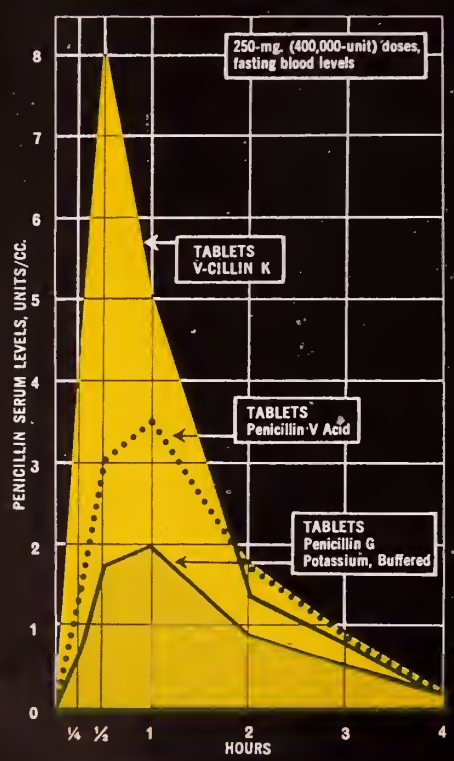
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The Journal of The Florida Medical Association
PUBLISHED MONTHLY

Volume XLIV | Jacksonville, Florida, December, 1957 | No. 6

Extracorporeal Circulation for Open Heart Surgery

I. Physiologic and Metabolic Studies

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Rufus K. Broadaway, M.D., John J. Fomon, M.D.
and
John J. Farrell, M.D.
Miami

The past decade has seen remarkable advances in cardiac surgery. Fundamental to its development has been the concept of "indirect" visualization by means of the intracardiac exploring finger. Use of this modality has resulted in the successful attack on stenotic lesions of the mitral and aortic valves and, more recently, mitral insufficiency.

Nevertheless, it is apparent that it is better to see than not to see. Although open heart surgery may be accomplished for short periods by hypothermia, it is clear that prolonged open cardiac corrective procedures require total body perfusion with bypass of the heart and lungs utilizing a pump-oxygenator. It is the purpose of this report to describe a relatively simple gas dispersion oxygenating mechanism of the DeWall type[1] and certain experimental physiologic and metabolic observations.

The Apparatus (Fig. 1)

The oxygenating unit consists of a simple nylon oxygen injector nipple through which large oxygen bubbles can be delivered into a vertical blood mixing tube, thereby creating a column of bloody foam. Oxygen and carbon dioxide exchange takes place in the upper portion of the mixing tube and throughout the entire length of a large defoaming chamber. In the latter, the bloody foam is reverted into a solid blood column by exposing it to Antifoam A,* which lines the defoamer. The blood is then delivered to a helical vinyl plastic reservoir mechanism. The theoretic advantages of a graduated helix over vertical debubbler mechanisms have proved to be sound in the laboratory. In the former, the blood column gradually descends, and any free gas bubbles tend to move away from the line of flow along the upper edge of the tubing. In the latter or vertical mechanism, the blood flow toward the reservoir runs in 180 degree opposition to the flow of the injected oxygen and the released carbon dioxide. Thus, the possibility of gas emboli is far greater in the vertical units.

The pumping mechanism consists of a model TM-1 valveless finger pump** capable of an output of approximately four liters of blood per minute.

Method

Mongrel dogs, weighing 8 to 30 Kg., were anesthetized with fractional doses of Pentothal Sodium, intubated and placed on a mechanical respirator. Surgery was performed clean but not aseptically. The chest was entered through the right fourth intercostal space. The right common carotid artery was exposed as was the right femoral artery. The pericardium was opened widely, and the inferior and superior venae cavae were mobilized and ligatures passed around these structures. After completion of all dissection, heparin was administered (1 mg. per kilogram). The femoral artery was then connected to a mercury

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This work was supported by the Heart Associations of Greater Miami and Palm Beach County, as well as the Hardt Foundation.
Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 7, 1957.

*Dow Corning Company, Midland, Mich.
**Sigmamotor, Inc., Middleport N. Y.

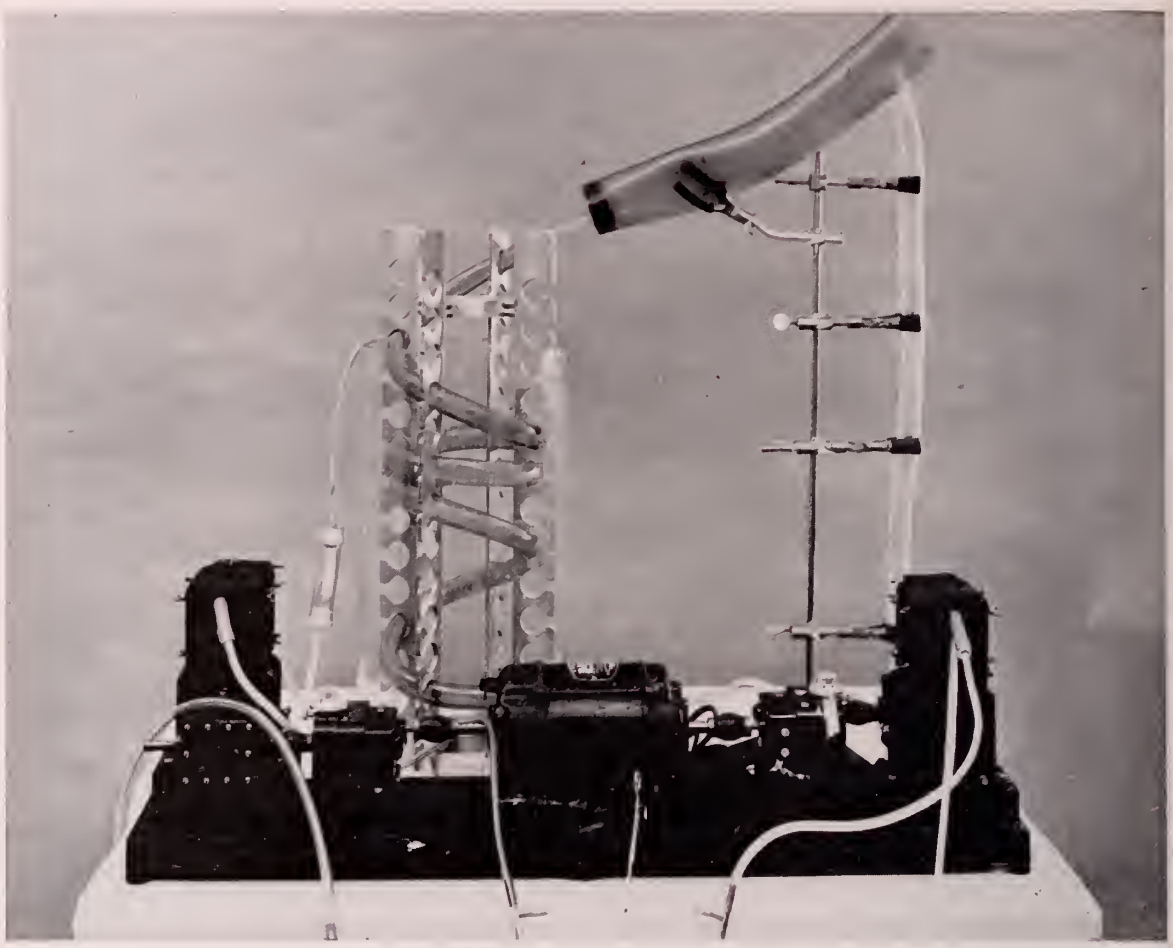


Fig. 1.—Fully assembled pump-oxygenator. The shunt between efferent and afferent lines is clamped.

manometer. Plastic cannulas were inserted into both cavae and the right common carotid artery. Following this procedure the arterial and venous connections with the pump-oxygenator were accomplished promptly.

During the initial preparations, the previously described apparatus was filled with freshly drawn blood heparinized with 18 mg. per 480 ml. of unmatched dog blood. Utilizing a shunt connecting the afferent and efferent limbs of the circuit, the entire reservoir volume of blood is recirculated through the oxygenating system immediately prior to total bypass. This measure effectively removes any trapped air bubbles.

Bypass of the heart and lungs was accomplished by occluding the shunt and tightening the caval ligatures about the cannulas. In the majority of animals, a right ventriculotomy was performed, and the blood returning to the right atrium via the coronary sinus and anterior cardiac veins was collected in a plastic reservoir by means of a low pressure suction device and returned to the oxygenator (fig. 2). At the conclusion of the perfusion, protamine sulfate, 2 mg. per kilogram, was administered to counteract the heparin effect.

Results

Seventy-three dogs have been perfused from 15 to 63 minutes. Induced potassium citrate cardiac arrest was performed in six animals. The data pertaining to the latter procedure will not be included in this report.

Forty-one (61 per cent) of the 67 animals survived perfusion, awoke, moved about and were alert to commands. Twenty-six animals (39 per cent) succumbed in the early postoperative period. The deaths were related to bleeding (9), atelectasis (12), acute cardiac failure (2), and cerebral ischemia (3). Seven dogs died on the first or second postoperative day of heart block produced during creation and repair of large ventricular septal defects. As might be expected, nine dogs succumbed from the third to seventh

postoperative days from empyema or massive wound infection.

A direct correlation between perfusion period and survival was demonstrable (fig. 3). Ten of 15 animals (67 per cent) perfused for 15 to 30 minutes survived. A second group of 42 dogs was perfused for 30 to 45 minutes. Thirty of these perfusions varied from 30 to 35 minutes. The remaining 12 bypasses varied from 35 to 45 minutes. There was an over-all survival of 26 dogs (61 per cent). Of 10 dogs perfused between 45 and 63 minutes only five survived.

A similar direct relationship between survival and flow rate is apparent in figure 4. Ten of 15 animals (67 per cent) perfused for 15 to 30 minutes survived. This number included six survivors in a group of eight dogs perfused at from 40 to 70 cc./Kg./min. while only three of six dogs lived after perfusion at 25 to 35 cc./Kg./min. One surviving dog was excluded from the analysis since the flow rate was varied significantly during the run. A second group of 52 dogs was perfused at the two rates described for periods of 30 to 60 minutes. There were 31 survivors (60 per cent). Four surviving animals were again excluded from analysis because of significant and frequent variations of flow rates during the runs. Twenty-four of 39 animals (61 per cent) perfused at 40 to 70 cc./Kg./min. survived while only three of 13 dogs (23 per cent) survived perfusion at 25 to 35 cc./Kg./min.

Acid Base Changes During Total Body Perfusion

A consistent fall in arterial pH occurred during perfusion. During the first 10 minutes of the run, the fall was small but significant. Beyond 10 minutes, the pH declined more rapidly. The fall in arterial pH could also be related to flow rate as well as perfusion period (fig. 5). Further, a direct correlation is demonstrable between survival and arterial pH at the end of the run (fig. 6). The lowest pH recorded was 6.9 (60 and 63 minute runs). There were no survivors in this group.

Figure 7 illustrates the essential metabolic picture during perfusion. These data were obtained from 14 animals perfused for 30 minutes at 25 to 77 cc./Kg./min. The pH drop described is again noted. There is a sharp fall in the arterial carbon dioxide content while the oxygen saturation remains at 96 to 98 per cent. By utilizing the arterial pH and carbon dioxide content data, it is possible to calculate the carbon dioxide tension of the arterial blood by application of the Henderson-Hasselbalch equation. As will be noted, there is a rise of considerable degree in the calculated pCO_2. On the basis of these determinations, it is apparent that a significant meta-

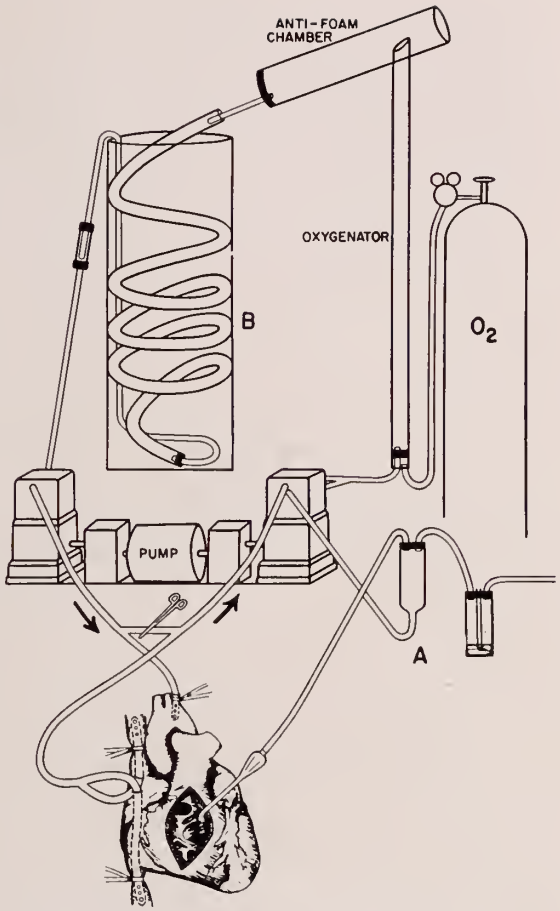


Fig. 2.—Diagramatic representation of unit in operation. The right ventricle is open and the low pressure cardiotomy suction system (A) is demonstrated. The helix (B) is immersed in a water bath maintained at 39 to 40 C. to maintain normothermic blood temperatures.

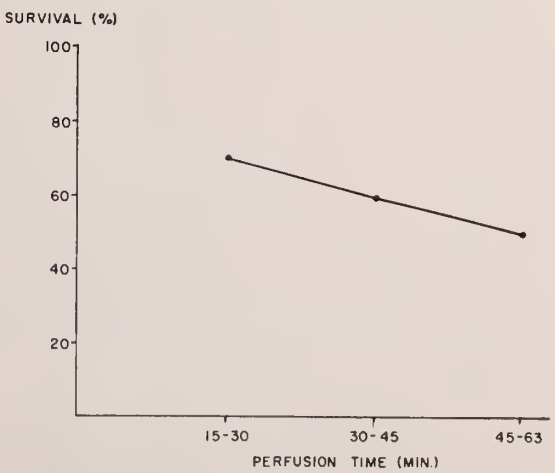


Fig. 3.—There is a linear relationship between survival and perfusion time.

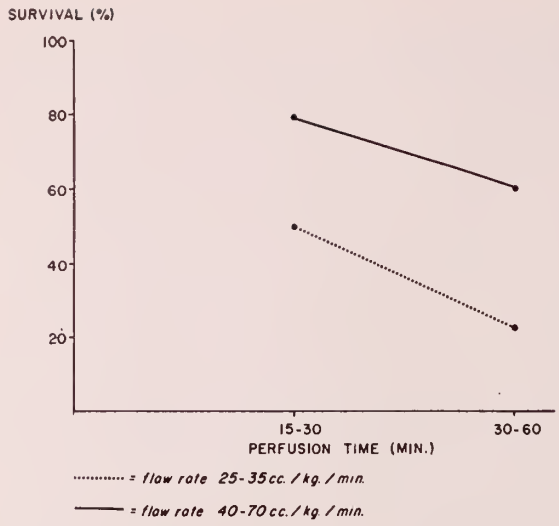


Fig. 4.—Effect of varying flow rates on survival.

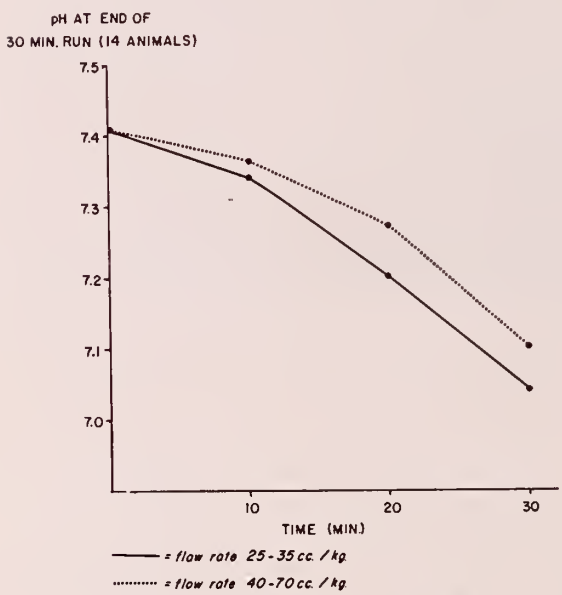


Fig. 5.—Effect of varying flow rates on pH.

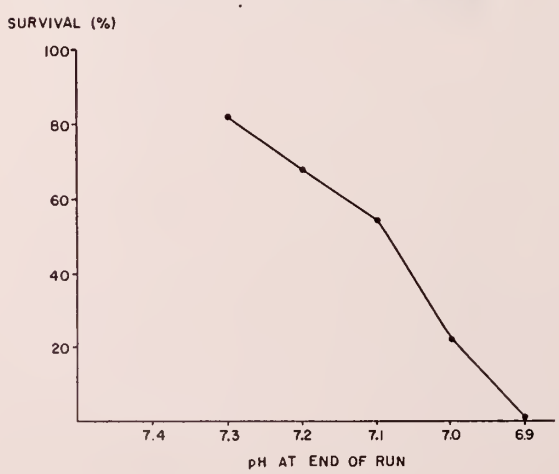


Fig. 6.—Relation between pH and survival.

bolic acidosis occurs during total heart-lung bypass. The probability that a significant degree of the acidosis is related to the accumulation of acid metabolites is suggested by the decided rise in lactic acid during the runs (table 1).

Alterations in the Blood and Blood Elements

Table 1 summarizes the influence of perfusion on hemolysis, potassium, sodium and leukocyte and thrombocyte counts. Although dog blood hemolyzes readily and the degree of hemolysis is often related to the care taken in obtaining the sample, plasma hemoglobin levels range from 79.2 to 143.1 mg. per hundred cubic centimeters with a mean value of 84.6 mg. These values are well within the realm of safety.

Serum sodium levels revealed no significant change, but there was a consistent lowering of potassium.

There were decided falls in leukocyte and thrombocyte counts during the perfusions, but these were transient and these elements rapidly reconstituted themselves shortly after perfusion was discontinued.

Discussion

It has been demonstrated that bubbling oxygen through a blood medium is a satisfactory method of rapidly oxygenating venous blood.[1-3] Despite varying flows, it has been uniformly possible to achieve oxygen saturations of 96 to 98 per cent. At the same time, the blow-off of carbon dioxide is quite efficient. A disquieting feature, however, has been the appearance of a significant metabolic acidosis. The magnitude of the acidosis is apparently related to both perfusion rate and time and materially influences ultimate survival. The rise in carbon dioxide

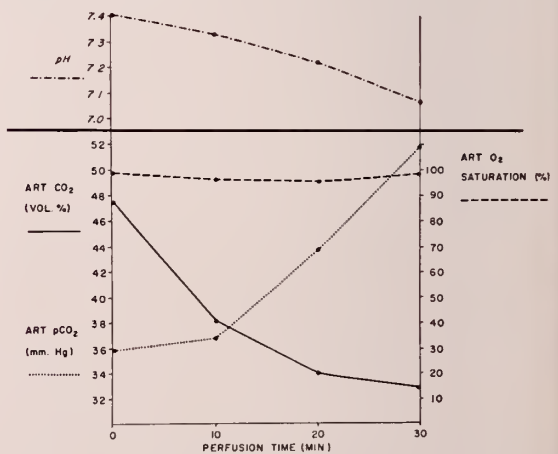


Fig. 7.—Metabolic data in 14 dogs. Discussion in text.

Table 1.—Alterations in Blood and Blood Elements

Time	Lactic Acid (mg. %) (6 dogs)	Plasma Hb. (14 dogs)	Potassium (14 dogs)	Sodium (14 dogs)	WBC (25 dogs)	Thrombocytes (14 dogs)
Before bypass	12.2	6.2	4.2	125	18,900	220,000
End of 30-45 min. bypass	37.6	84.6	3.6	128	5,000	49,000
½ hour post perfusion	31.2	76.2	3.7	125	7,600	72,000

Perfusion rate 40 to 63 cc./Kg./min.

tension of the arterial plasma accounts for only a portion of the metabolic derangement, and it is probable that the major drop in pH is related to accumulation of fixed acid metabolites, thereby effectively tying up the buffer systems. Whether or not a pronounced depression of renal function is responsible for the inability of the organism to cope with the acidosis is unclear at this time and must await further laboratory inquiry. It is of interest that an elevation of fixed acids and an associated fall in arterial pH occur at flow rates approximating normal cardiac output. It is conceivable that there may be profound disturbances in the enzyme systems of the tissues so that adequate function of the normal metabolic pathways does not occur despite perfectly adequate delivery of blood to the tissues. If the acidosis were merely a function of tissue hypoxia, it would seem that there should be an associated elevation of potassium.[4] The fact that there was a distinct fall in the cation suggests a possible epinephrine effect since the latter has been shown to be of significant importance in lowering serum potassium.[5] Further, it is known that administration of epinephrine alone produces decided elevations of fixed acids.[6] Thus, it is possible that an epinephrine-like effect (perhaps mediated through the adrenal medulla) is one of the basic mechanisms underlying the acidosis.

The rapid fall in leukocytes and platelets during the perfusions is not surprising and is consistent with the findings of other investigators.[7,8] As indicated previously, these two elements rapidly reconstitute themselves to a large extent within one hour after perfusion. Hemolysis was of moderate degree and never reached dangerous levels.

Summary

Experimental data on 67 animals subjected to total heart-lung bypass by utilization of a simple pump-oxygenator are presented. Oxygenation was consistently above 96 per cent at varying flow rates, and elimination of carbon dioxide was most efficient. A significant metabolic acidosis developed during the runs, which correlated with both perfusion time and rate. A definite relationship between drop in pH and survival is demonstrable. The possible mechanism of the acidosis is discussed.

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1000 N. W. Seventeenth Street (Dr. Litwak).

The Clinical Value of Right and Left Heart Catheterization in the Selection of Patients For Valvular Heart Surgery

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ROBERT S. LITWAK, M.D., MIAMI
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MIAMI BEACH

The successful surgical intervention on stenotic lesions of the mitral and aortic valves has focused attention on the necessity for critically selecting possible candidates for surgical therapy. In the past, physiologic evaluation of these lesions consisted of right heart catheterization alone. The value of this procedure is limited because of the difficulty in separating the effects of mechanical valvular block from those of myocardial insufficiency (the myocardial factor[1,2]) and from those of pulmonary vascular lesions. This is especially true in aortic stenosis, in which direct measurement of left ventricular dynamics is manifestly impossible since the most distal point reached by the catheter is the pulmonary "capillary bed." Elevated pressures in this condition ("pulmonary capillary pressure") have been employed as evidence of left atrial hypertension due to a stenotic mitral valve. Normal "pulmonary capillary pressure" has been interpreted as evidence for the absence of physiologically significant mitral stenosis. Preliminary studies with right and left heart catheterization have shown that these concepts are open to serious doubt.

The demonstration of pulmonary hypertension at rest or on exercise[1,2] (in the absence of left ventricular failure) has emerged as the most valid criterion of mitral valve obstruction when right heart catheterization is employed alone. It will subsequently be demonstrated, however, that the absence of severe pulmonary hypertension at rest or on exercise does not necessarily preclude the existence of physiologically and clinically significant mitral stenosis.

Recognition of the limitations of right heart catheterization led to the development of methods permitting direct measurement of left atrial and left ventricular pressures. These methods include transbronchial, suprasternal, and posterior percutaneous approaches.[3-8] A modification of the Fisher percutaneous technic has been employed in the studies reported herein.

In the normal subject, left atrial and left ventricular pressures are virtually identical in diastole as are left ventricular and central aortic pressures during systole. The existence of a left atrial–left ventricular diastolic pressure difference, or a left ventricular–aortic systolic pressure difference is indicative of mechanical obstruction of the mitral or aortic valves respectively. This pressure differential across either valve is defined as a gradient. Mean gradient is a planimetrically determined average gradient in either diastole or systole. These gradient concepts are specifically applicable to conditions of normal blood flow. It is not known with certainty whether or not small systolic or diastolic gradients may occur normally when the cardiac output is high, that is, during exercise, with congenital or acquired left-right heart shunts, or with such entities as hyperthyroid heart disease.

In order to maintain blood flow across the stenotic mitral valve, left atrial pressure must rise. As a result, a diastolic left atrial–left ventricular gradient appears (fig. 2). Similarly, a left ventricular–aortic systolic gradient develops consequent to a stenotic aortic valve (fig. 3). Since the magnitude of the mean valvular gradient is dependent upon both the size of the valve orifice and the flow across the valve, that is, the cardiac

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Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 7, 1957.

Director, Cardio-Pulmonary Laboratory, Mt. Sinai Hospital, and Assistant Professor of Medicine (Dr. Samet), Assistant Professor of Surgery, University of Miami School of Medicine (Dr. Litwak), and Public Health Service Research Fellow, National Heart Institute (Dr. Silverman).

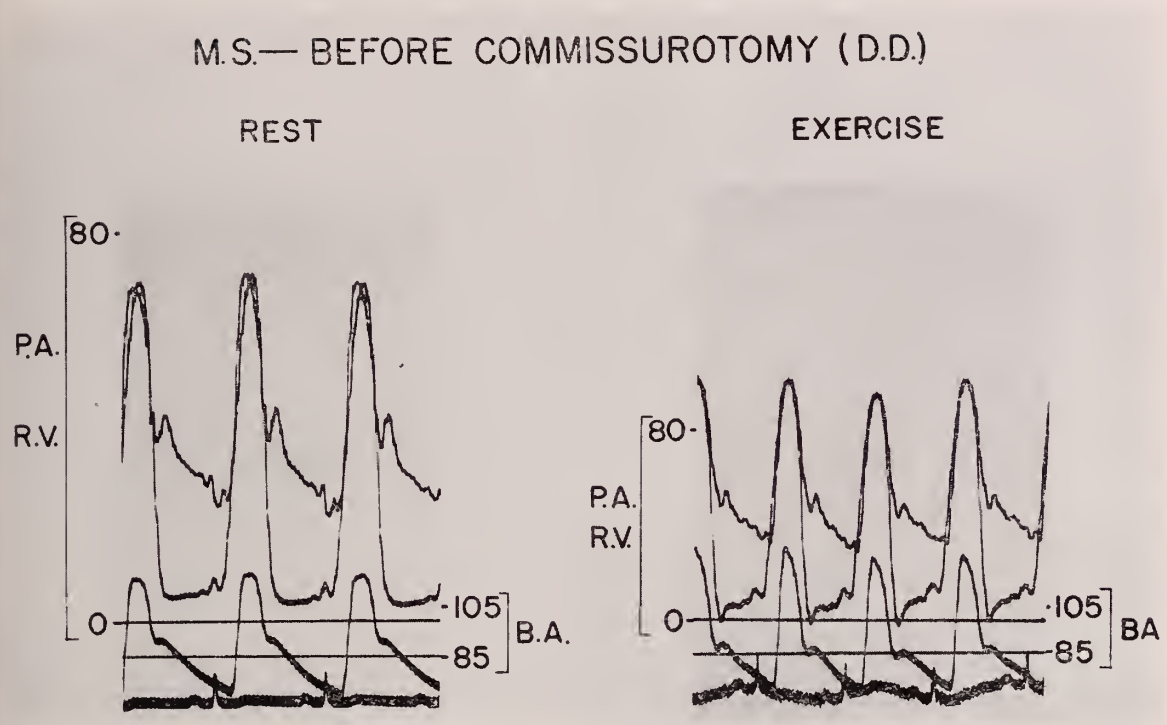


Fig. 1.—Right heart catheterization data on a 40 year old white man with mitral stenosis (case 1). There is pronounced pulmonary hypertension at rest with a further increase on exercise. Paper speed is 25 mm. per second; the time lines are at 0.04 second intervals. P.A.—pulmonary artery. R.V.—right ventricle. B.A.—brachial artery. The baselines and sensitivities are indicated on either side of the figure.

output (as well as upon the heart rate), it is clear that the recorded gradient is materially influenced by variations in flow.

Cardiac output (flow) is determined by right heart catheterization utilizing the Fick formula; the valvular gradient is obtained by left heart catheterization. Thus, combined left and right heart catheterization is necessary to assess the true physiologic significance of the gradient across the valve. Fifty-four such studies form the basis of this report.

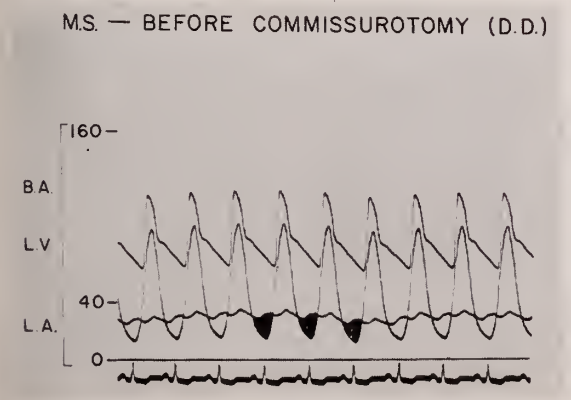


Fig. 2.—Preoperative left heart catheterization data in the same patient. The left atrial hypertension and the mean diastolic left atrial–left ventricular pressure gradient are readily noted. The blackened areas outline the gradient. L.V.—left ventricle. L.A.—left atrium.

As illustrated by Braunwald and his associates,[9] simultaneous recording of left heart pressures in the operating room, before and immediately after mitral commissurotomy, is of primary importance in helping to decide whether an adequate commissurotomy has been performed.

Method

Right heart catheterization was performed in the usual manner in the supine position in the basal postabsorptive state. Multiple steady state pressure and cardiac output determinations were

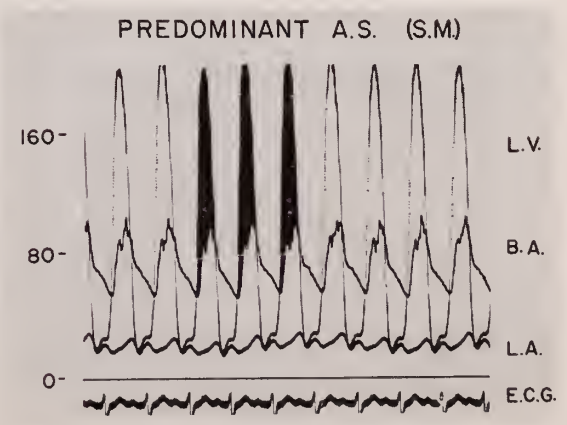


Fig. 3.—Aortic stenosis in a 50 year old white man. The mean systolic left ventricular–brachial artery pressure gradient is 68 mm. Hg (the blackened areas).

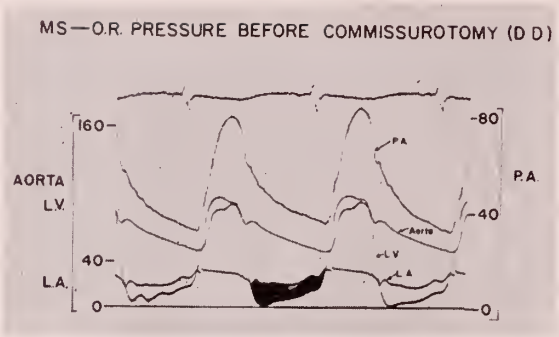


Fig. 4.—Operating room precommissurotomy pressures in the same patient as in figures 1 and 2. Paper speed 75 mm. per second; the time lines are at 0.04 second intervals.

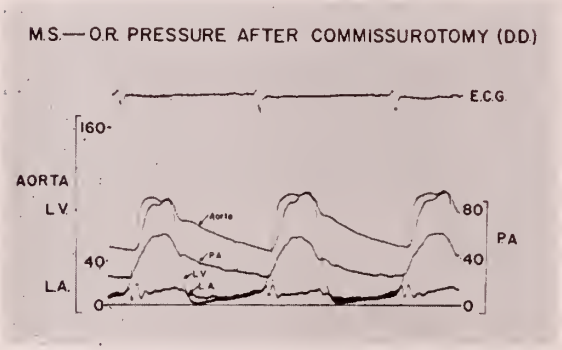


Fig. 5.—Operating room postcommissurotomy pressures. The decided fall in the left atrial–left ventricular gradient is to be noted.

made at rest, during exercise, and on recovery. With the right heart catheter and brachial artery needle in situ, the patient was turned into the prone position. Repeat right heart pressures were obtained. Fifty to 100 mg. of Demerol was subsequently given via the catheter to some patients.

Left heart catheterization was performed via a modification of the posterior percutaneous puncture technic of Fisher.[8] Fluoroscopic visualization of the left atrium was carried out with the patient in the prone position. Two 6 inch No. 17T thin-walled styletted needles were inserted into the left atrium. Polyethylene tubing was passed through these needles into the left atrium and left ventricle. On several occasions, the aorta was successfully catheterized by this left heart route. Simultaneous pressures were then obtained (from the same baseline and at identical or similar strain gauge sensitivities[9]) from the left atrium, left ventricle, and aorta or brachial artery. Initially, these latter pressures were recorded with Statham P23 AA strain gauges, on a six channel cathode ray photographic recorder.* Of late, the latter gauges have been employed for right heart and brachial artery curves and Statham P23D or P23G gauges for the left heart curves.

In the more recent studies, the 6 inch needles have been removed over the left heart polyethylene catheters in the prone position. The patient is

*Electronics for Medicine, White Plains, N.Y.

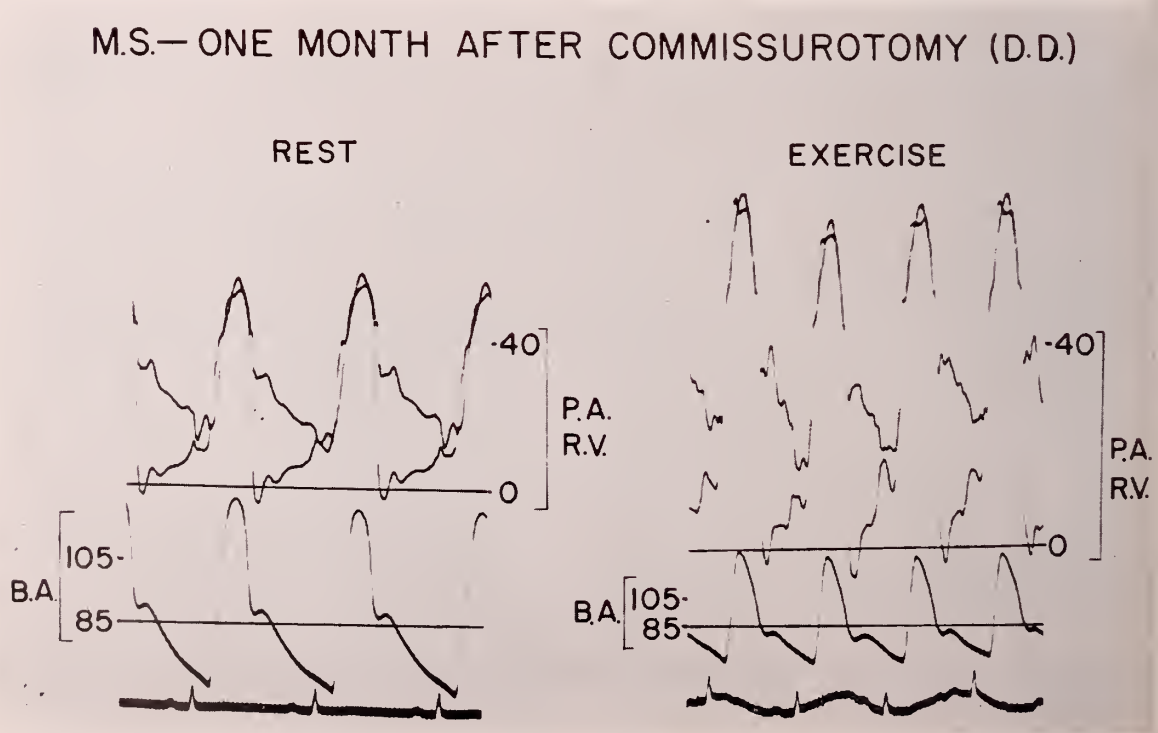


Fig. 6.—Right heart catheterization one month after surgery. There has been a decrease in the level of pulmonary hypertension both at rest and on exercise.

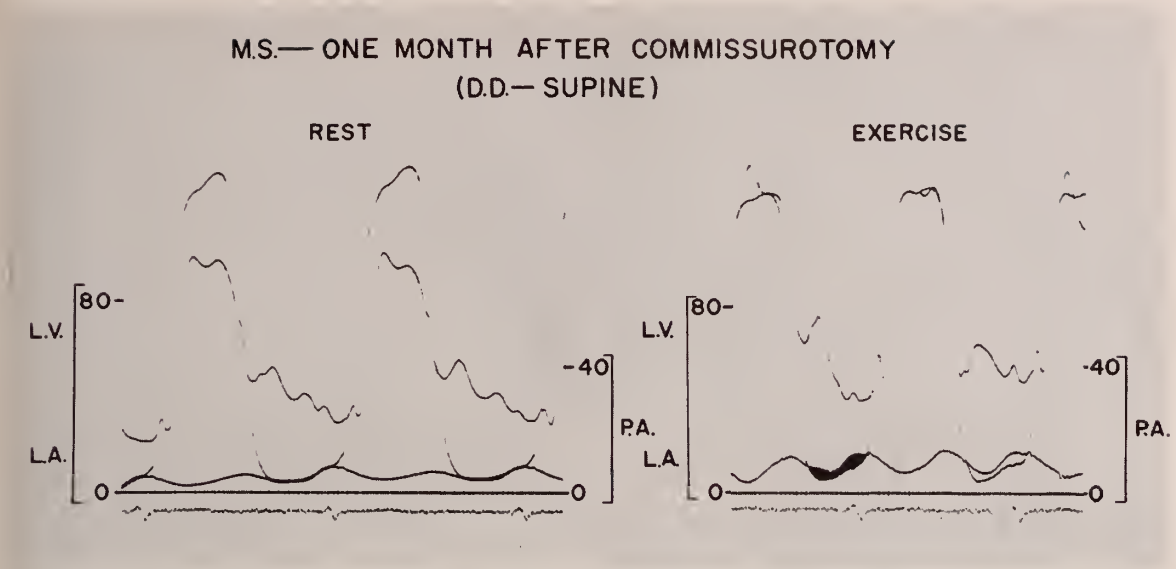


Fig. 7.—Left heart catheterization data at rest and on exercise one month after surgery. A small gradient (1 mm. Hg) is present at rest; the gradient rose to 4 mm. Hg during exercise.

then rotated back into the supine position and repeat cardiac output and pressure studies recorded from the left atrium, left ventricle and pulmonary artery at rest, during exercise, and on recovery. Nineteen studies have been performed in this fashion.

Simultaneous pressures, from the same baseline and at identical strain gauge sensitivities, were obtained from the left atrium, left ventricle, and aorta in the operating room, both prior to and subsequent to the mitral commissurotomy. Pulmonary artery pressures were recorded at the same time. These served as a guide to adequate opening of the stenotic left heart valve.

Results

Preoperative data on a 40 year old white man are illustrated in figures 1 and 2 (case 1). There is severe pulmonary hypertension at rest with a further increase on exercise. This suggests the presence of a mechanical block at the mitral valve

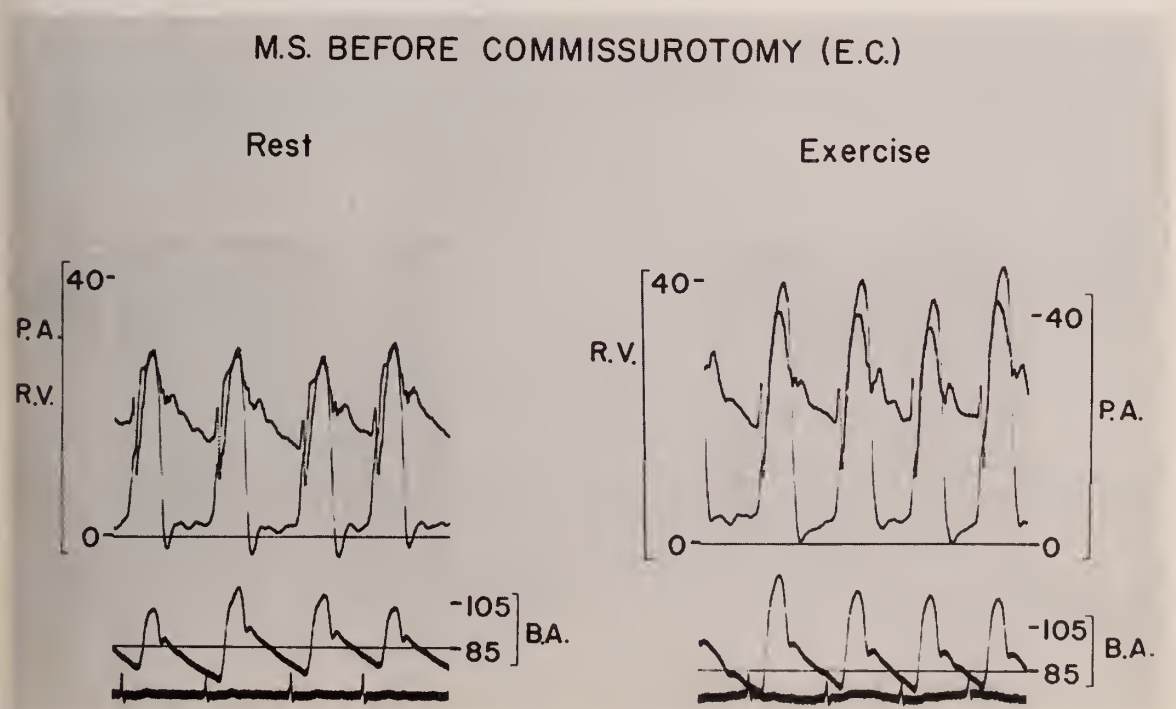


Fig. 8.—Right heart catheterization data on a 48 year old white man (case 2). There is minimal pulmonary hypertension at rest with a slight rise during exercise.

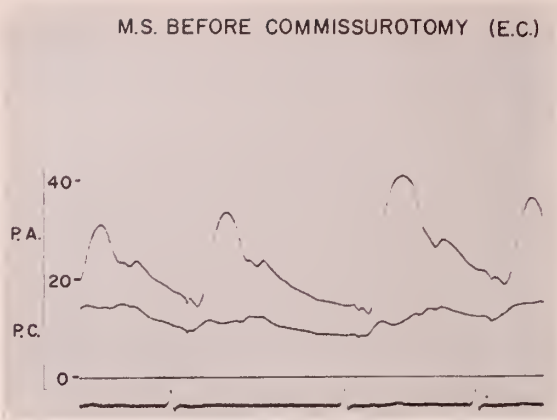


Fig. 9.—The "pulmonary capillary pressure" is at the upper limit of normal at rest; same patient as in figure 8.

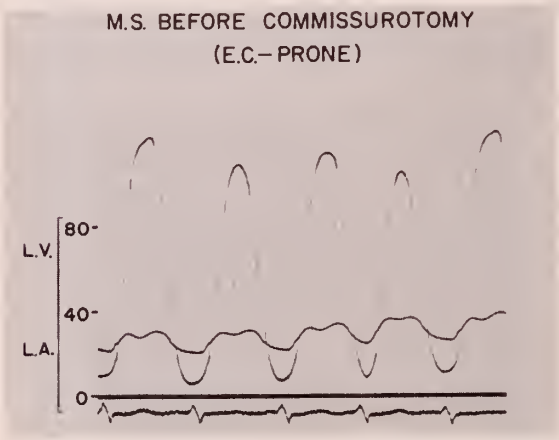


Fig. 10.—Despite the normal "pulmonary capillary pressure" (fig. 9), there is a pronounced left atrial–left ventricular diastolic gradient.

since there was no evidence of left heart failure. The existence of a mean diastolic left atrial–left ventricular gradient of 11 mm. Hg (at rest prone) is unequivocal proof of such a block. The findings at surgery substantiated the postulation of tight mitral stenosis. The valve was opened widely without production of regurgitation. Figure 4 illustrates the precommissurotomy operating room data, and figure 5 the postcommissurotomy data.

The postoperative left atrial–left ventricular mean diastolic gradient is only 2 mm. Hg; there has also been a sharp fall in pulmonary artery pressure. The findings on repeat cardiac catheterization one month after surgery are shown in figure 6. There has been a considerable decrease in the level of pulmonary hypertension both at rest and during exercise. The residual left atrial–left ventricular gradient, in the supine position, is 1 mm. Hg at rest and 4 mm. Hg on exercise (fig. 7). Current data do not permit a decision as to whether this represents a minimal degree of residual stenosis or is a physiologic phenomenon related to increased flow across the valve. The preoperative catheterization data described represent what is considered to be the classical hemodynamics of tight mitral stenosis. The residual pulmonary hypertension noted one month postoperatively is in all probability secondary to pulmonary vascular lesions, in the absence of left ventricular failure and in the presence of so small a residual left atrial–left ventricular mean diastolic gradient. Repeat study 10 months after surgery revealed further regression in the level of pulmonary hypertension with gradients of 1 and 3 mm. Hg at rest and exercise respectively.

The physiologic data on a 48 year old white man are shown in figures 8 to 10 (case 2). Right heart catheterization (fig. 8) revealed borderline pulmonary hypertension at rest with a minimal increase on exercise. The mean "pulmonary capillary pressure" at rest (fig. 9) was at the upper limit of normal, 12 mm. Hg. These data might well suggest the absence of a significant mechanical mitral block. The left heart tracings, however, clearly demonstrate dynamically significant mitral

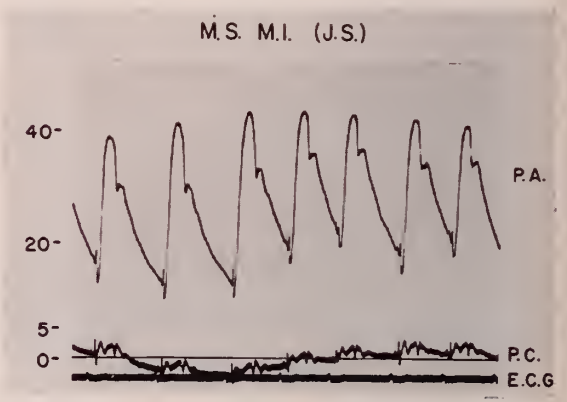


Fig. 11.—Mitral stenosis and regurgitation in a 48 year old white man. The mean "pulmonary capillary pressure" is zero.



Fig. 12.—Same patient as in figure 11. The mean diastolic left atrial–left ventricular gradient is apparent. In addition, the left atrial tracing is most suggestive of mitral insufficiency. Left atrial hypertension is present.

stenosis, which was subsequently proved at surgery (fig. 10).

Further illustration of the limited value of the "pulmonary capillary pressure" is shown in figures 11 and 12 (case 3.). The patient, a 48 year old white man, has both mitral stenosis and insufficiency. The mean "pulmonary capillary pressure" (fig. 11) is well within normal limits. The existence of left atrial hypertension and the presence of a diastolic gradient across the mitral valve are revealed solely by left heart catheterization (fig. 12). The atrial curve is consistent with the clinical evidence of associated mitral regurgitation.

The value of operating room pressure curves is illustrated in figures 13 to 15. The precommissurotomy gradient is 23 mm. Hg. Upon completion of the first attempt at commissurotomy, the gradient was still 11 mm. Hg (a level indicating the need for surgical intervention in a preoperative study) despite the statement by an experienced cardiac surgeon that an adequate commissurotomy had been performed. Further valve fracture reduced the gradient to 2 mm. Hg.

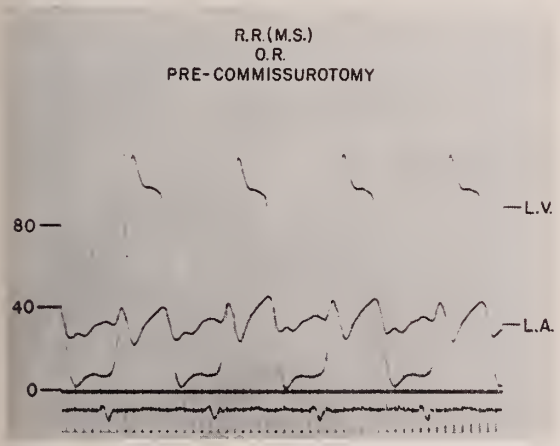


Fig. 13.—Operating room precommissurotomy pressures in a 30 year old white woman. The left atrial–left ventricular gradient is 23 mm. Hg.

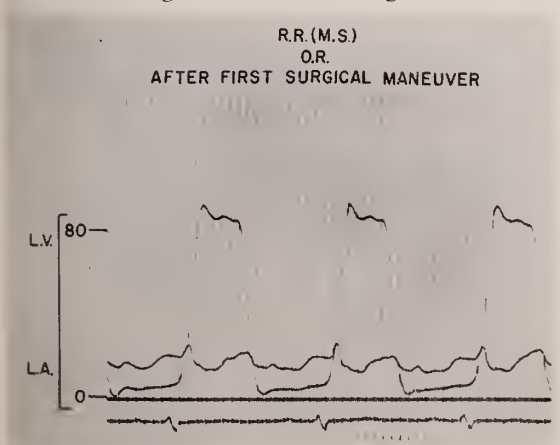


Fig. 14.—The gradient is 11 mm. Hg.

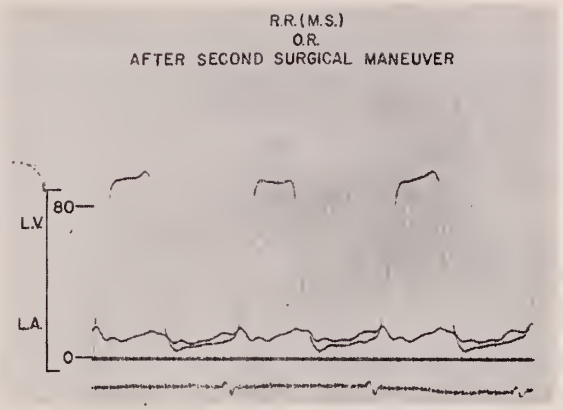


Fig. 15.—The gradient is 2 mm. Hg.

CARDIAC OUTPUT DATA
S.J. 11/29/56 B.S.A. 1.73

OUTPUT NUMBER	CARDIAC INDEX (L./Min./M² B.S.A.)	OXYGEN CONSUMPTION (ml./Min./M² B.S.A.)	A-V DIFFERENCE Vol. %)	R
1.	2.33	138	5.9	.77
2.	2.30	136	5.9	.84
3.	2.32	135	5.8	.84
4. (2½ Min.)	2.49	192	7.7	.85 (exer.)
5. (6 3/4 Min.)	2.68	217	8.1	.85 (exer.)
6.	2.37	138	5.8	.81
7. (7 Min.)	2.70	227	8.4	.84 (exer.)

Fig. 16.—Multiple cardiac output determinations during right and left heart catheterization. Note the similarity in the resting cardiac outputs, oxygen consumption and respiratory quotient.

The feasibility of steady cardiac output determination during combined heart catheterization is illustrated in figure 16. The fourth output (at two and one-half minutes exercise) is during an unsteady state. The last two outputs (Nos. 6 and 7) are during combined heart catheterization; the first five outputs are during right heart catheterization alone.

Discussion

Prior to the availability of left heart catheterization, no direct measure of the pressure difference between left atrium and left ventricle was possible. Since this pressure gradient is the physiologic hallmark of mitral stenosis and since the interpretation of "pulmonary capillary pressure" is a controversial subject[10] and is at best subject to error, as indicated, the necessity for direct measurement of this gradient becomes self evident. The interrelationships between the mean systolic or diastolic gradient, the cardiac output, and the heart rate render determination of all three variables a necessity for physiologic evaluation of patients with mitral and/or aortic stenosis.

The clinical utility of combined heart catheterization is well illustrated by the patient in case 2.

Previous physiologic studies in rheumatic heart disease[1,2] have delineated the subject with mitral stenosis in whom surgery is of little or no value. Minimal or absent pulmonary hypertension at rest and during exercise, and a low cardiac output at rest with a limited increase on exercise (the myocardial factor) characterize this type of patient. After right heart catheterization alone, therefore, surgery would not have been advised in this patient. The finding of a large left atrial–left ventricular gradient at rest points out the potential error in this approach; the findings at surgery confirmed the belief that a stenotic mitral valve was present. The residual pulmonary hypertension in case 1 one month after surgery could per se raise doubts as to whether or not the mitral valve was adequately opened at surgery. The minimal left atrial–left ventricular gradient is proof that the residual pulmonary hypertension is due to pulmonary vascular lesions, in the absence of left ventricular failure.

Three physiologic parameters are needed to evaluate the size of the mitral valve. These include cardiac output, mean diastolic left atrial–left ventricular gradient, and the heart rate. Only combined heart catheterization affords a means of determining these variables.

Summary

In view of the growing importance of surgery for rheumatic heart disease and because of the difficulties in adequate selection of cases on clinical grounds alone, physiologic study of the type discussed is needed: (a) to avoid unnecessary surgery in some patients; (b) to permit critical selection for surgical intervention in other subjects; (c) to provide immediate information to the surgeon in the operating room as to the adequacy of the commissurotomy; and (d) to permit long term clinical and physiologic evaluation of the effect of the operative procedure upon the clinical course of the disease process.

At least some of the instances of recurrent mitral stenosis reported in the literature may well be due to failure to open the valve properly at the time of initial surgery.

Mitral commissurotomy was performed as indicated in these patients by Drs. Robert S. Litwak, DeWitt C. Daughtry, Francis N. Cooke, and Myron I. Segal.

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The Diagnosis and Management Of Ectopic Pregnancy

Frank R. Smith, M.D.
and
William H. Whiteside, M.D.
New York

It is apparent from the rather abundant literature on the subject of ectopic pregnancies that many authors believe them to be increasing in number. Kohl, Tricomi and Siegler[1] stated that the incidence of tubal pregnancies in 1951 was twice as great as in 1942. There is, however, some evidence that the increase is in proportion to an increase in the number of births in the individual clinics reporting. At New York Lying-In Hospital[2] there were 351 ectopic pregnancies during the years 1932-1955, and 117 of these occurred from 1951 to 1955. Yet in proportion to pregnancies in this clinic for the same years, there was little difference, as is shown in table 1.

From table 1 it would seem that the increase is more apparent than factual. From Roosevelt Hospital, which has no obstetric service for comparison, Crawford, Wichern and Cave[3] reported 57 ectopic pregnancies in the 10 year period from 1940 to 1951. There have been 51 patients with ectopic pregnancy during the five year period from 1951 to 1955. This increase, while questionable, seems apparent. The use of antibiotics as therapy for salpingitis with resulting canalization of the tubes has been suggested as the explanation for this apparent increase, but this explanation is based on the questionable assumption that most ectopic pregnancies are preceded by chronic salpingitis. At the University of Helsinki, 1,158 patients operated on for ectopic pregnancy showed a 20 per cent rate increase from 1945 to 1953, and 60 per cent had had previous antibiotic treatment for genital infection.[4]

Table 1. — Ectopic Pregnancies at New York Lying-In Hospital

Year	Number of Ectopic Pregnancies	Number of Births	Per Cent of Ectopic Pregnancies
1932 - 1950	234	62,561	0.4
1951 - 1955	117	22,656	0.5
1932 - 1955	351	85,217	0.4

From the Gynecology Service of Roosevelt Hospital, New York. Dr. Whiteside is the Resident in Gynecology at Roosevelt Hospital.

Read before the Florida Obstetric and Gynecologic Society, Ninth Annual Meeting, Miami Beach, May 13, 1956.

Prior to 1900, ectopic gestation was justly considered a catastrophe.[5] From 1900 until adequate blood replacement was possible, the mortality was estimated at 4 to 8 per cent. Kohl and his associates,[1] in an excellent article, reported that in 454 consecutive cases of ectopic pregnancy at King's County Hospital in Brooklyn (1942-1951) the diagnosis was correct in 89 per cent with four deaths, or a mortality of 1.3 per cent. Yet Rosenthal and Glass[6] stated that in Brooklyn, from 1937 to 1950, there were 64 maternal deaths from early ectopic gestation. The diagnosis was incorrect in 30 of the 64 cases, or 47 per cent. In 18 other cases, although tubal pregnancy was suspected, therapy was delayed sufficiently to cause death.

When a patient of child-bearing age, who is in shock with an acute condition of the abdomen requiring surgical intervention, has a history of sudden onset of abdominal pain, amenorrhea, scanty periods, or excessive bleeding, and a doughy pelvic mass is detected, the diagnosis of ruptured ectopic gestation is relatively easy and will be correct in 90 per cent of such cases. Formerly, emphasis was placed on a history of a previous ectopic pregnancy, of infertility, or of a long time interval since the previous pregnancy. Unfortunately, many patients do not present so clear and classical a picture. Conditions that can be easily confused with ectopic pregnancies include acute appendicitis, diverticulitis, ruptured hemorrhagic ovarian cyst, torsion of the pedicle of an ovarian cyst, acute salpingitis, endometriosis and intestinal obstruction. During the years 1940 to 1951 at Roosevelt Hospital, Crawford and his associates[3] reported 57 ectopic pregnancies with 91 per cent accurate preoperative diagnoses and one death due to congestive heart failure following surgery. There was no death from hemorrhage. During the same years 52 other surgical emergencies simulating ectopic pregnancy were encountered. These are briefly commented upon in tables 2 to 5.

Surgical Emergencies Simulating Ectopic Pregnancy

As shown in table 2, ectopic pregnancy was suspected in only four of the 52 cases. The predominance of a preoperative diagnosis of appendicitis and right-sided lesions in this series suggests that with left-sided ruptured cysts there was recovery without operation and perhaps many of the operations were unnecessary for cure of the patient.

Table 2. — Ruptured Hemorrhagic Ovarian Cysts at Roosevelt Hospital

52 surgical emergencies in 10 years—1940-1951
Preoperative diagnosis of appendicitis in 40 cases
Right ovary site of rupture in 48 of 52 cases
Ectopic pregnancy suspected in only 4 cases

In the 18 cases of torsion of ovarian cysts (table 3), six cysts were dermoids, nine were simple cystomas, two were corpus luteum, and one was parovarian. There were no pseudomucinous cysts. The commonest symptom syndrome was recurrent episodes of pain with nausea, but all of the patients had sudden severe attacks before surgery.

Table 3. — Torsion of Ovarian Cysts at Roosevelt Hospital — 1940-1951

Total	18 cases	
Correct preoperative diagnosis	8 cases	44.0%
Youngest patient	8 years	
Oldest patient	80 years	
Appendicitis suspected	6 cases	33.3%

In table 4 the therapy for acute salpingitis is outlined. In some cases, even if ectopic pregnancy is suspected, delay in operating is justified long enough to complete tests for diagnosis.

Table 4. — Acute Salpingitis

If the diagnosis is definitely established, surgery is not indicated
If there is evidence of progressive or ascending peritonitis, prompt surgery is indicated
Drainage through a posterior colpotomy for abscess is indicated
In certain situations laparotomy is indicated

Table 5 summarizes the cases of endometriosis in which an acute condition of the abdomen requiring surgery was present. Ectopic pregnancy was considered, but the preoperative diagnosis was intestinal obstruction.

Table 5. — Endometriosis with Acute or Subacute Intestinal Obstruction

Obstruction	Cases
Partial obstruction	5
Complete obstruction	2
Endometriosis involving terminal ileum	3
Lesions requiring intestinal resection	4

Analysis of Ectopic Pregnancy Series

With these facts in mind, we decided to analyze the 51 cases of ectopic pregnancy in which the patient was operated upon at Roosevelt Hospital from 1951 to 1955. Fully realizing the futility of statistics in so small a series, we made this study with the intention of determining history characteristics and patient behavior and findings as well as methods of diagnosis, delays in therapy and errors in diagnosis — not for comparison with statistics from other clinics.

Table 6 shows the age distribution, which naturally falls entirely within the child-bearing age limits.

Table 6. — Age of Patients Having Ectopic Pregnancy at Roosevelt Hospital—1951-1955

Age	Number
Under 20	2
20 - 29	26
30 - 39	20
40 - 50	3
Total	51

Thirty-nine of the 51 patients had previously had at least one birth and one abortion (table 7). Only two patients had not been pregnant previous to this pregnancy, although 30 patients had previously had at least one abortion. This analysis somewhat reduces the impression of the importance of a history of infertility when ectopic gestation is suspected. Only two patients had previously experienced an ectopic pregnancy, or 3.9 per cent. This figure is in keeping with the 3.0 per cent reported by Ware and Winston,[7] but less than the 16.0 per cent recurrence reported by Bender,[8] or the 6.3 per cent reported by Kohl and his associates.[1]

Table 7. — Parity in Patients with Ectopic Pregnancy at Roosevelt Hospital—1951-1955

	None	One	Two	Three	Four	More than four	Total
Births	24	16	3	7	0	1	51
Gravidity	2	13	15	11	7	3	51
Abortions	30	15	5	1	0	0	51
Abortions and births	39	10	2	0	0	0	51

Note: Only two patients had had a previous ectopic pregnancy (3.9 per cent).

Only eight of the 51 patients had had previous operations, as shown in table 8, and this group included two patients with previous ectopic pregnancies. Grant[9] was of the opinion that 50 per cent of ectopic pregnancies occur after tubal operations.

Table 8. — Previous Operations in Eight of Fifty-One Patients

Plastic operation on fallopian tubes	1
Pelvic inflammatory disease	1
Cyst, ovarian	1
Cyst, abdominal	1
"Tubal ligation" at 23 years; 2 children, 3 abortions	1
Appendectomy and partial salpingectomy	1
Ruptured ectopic pregnancy (previous)	2

Previous illnesses, listed in table 9, occurred in 15 of the 51 patients. Only two had definite inflammatory disease although in two others the diagnosis was in doubt. In this series genital infection played a smaller part in the occurrence of ectopic pregnancy than is generally supposed.

Table 9. — Previous Illnesses

Past History	Number of Patients
Pelvic inflammatory disease, with penicillin	2
Pelvic inflammatory disease, without antibiotics	1
Duodenal ulcer	1
Tuberculosis	1
Fibroid tumor	1
Intestinal parasites	1
Cysts of breast	1
Ovarian cyst (pelvic inflammatory disease?)	2
Post polio	1
Illegal abortion	1
Bladder infection	1
Pyelonephritis	1
Infectious hepatitis	1
	15 of 51 patients

Previous admissions to any hospital are tabulated in table 10. Sixteen of the 51 patients were included in this category. While only two patients had presented evidence of definite pelvic inflammatory disease, the predominance of some infection is worth noting.

Pain and some type of bleeding were the most characteristic symptoms (table 11). Amenorrhea was less frequent than bleeding or oligomenorrhea.

Table 11. — Symptoms

Symptoms	Number of Patients
Pain	47
Bleeding	26
Amenorrhea	2
Oligomenorrhea	27
Pain alone	8
Bleeding alone	1
Amenorrhea alone	1
Oligomenorrhea alone	0
Pain and bleeding	13
Pain and amenorrhea	1
Pain and oligomenorrhea	15
Pain, oligomenorrhea and bleeding	10
Bleeding and oligomenorrhea	2
Total	51

It is shown in table 12 that 30 patients had previous attacks of fainting or pain before the attack that precipitated hospital admission, and 10 patients fainted at the time of admission.

Table 12. — Patients With Syncope

Type	Number of Patients
Previous attacks of pain before admission	19
Fainted first on admission	10
Previous fainting attacks	11
Nausea and vomiting with pain	13
Nausea and vomiting without pain	2
Diarrhea with pain	3
Diarrhea without pain	0
Drop in blood pressure before surgery	11

Table 13 summarizes the laboratory findings. Pregnancy tests, when made, were of less value than usually expected. The reaction was negative in four of the 13 cases in which such tests were

Table 10. — Previous Admission to Any Hospital

Observation	Pelvic Inflammatory Disease	Threatened Abortion	Other Reasons
r of ; (16) 1	4	2	9
One week before returned for operation for ectopic pregnancy	1-13 days before 1-5 years, pelvic inflammatory disease 1-7 years, gonococcal infection 1-2 years, tuberculosis	1-1 week before dilatation and curettage, negative colpocentesis 1-11 days before dilatation and curettage for incomplete abortion	1 - 10 years, tubal ligation 2 - office cautery 22 days before unruptured ectopic pregnancy and ovarian cyst 1 - 7 years, carcinoid appendix 1 - 3 years, right hydronephrosis and pyelonephritis 1 - 6 admissions for induced abortion 1 -4 years, ectopic pregnancy 1 - post polio 1 - hematosalpinx, question of pathology 1 - hematosalpinx with bilateral salpingitis

atory

made. Roentgenograms of the abdomen with the patient in the supine position were taken in only six cases, but gave significant findings in five. Sedimentation tests in 11 cases showed an elevation in three. The leukocyte count in 36 cases was higher than 10,000 and less than 10,000 in only 11 cases. In four cases a leukocyte count was not made.

Table 13. — Laboratory Findings

Type of Test	Number of Patients
Achheim-Zondek test	13 (9 positive, 4 negative)
Hemoglobin less than 10 Gm. on admission	8
Hemoglobin fell after admission	4
Fall in blood pressure before surgery	11
Deteriorated before surgery	12
Leukocyte count more than 10,000	36
Leukocyte count less than 10,000	11
Leukocyte count not made	4
Sedimentation rate	11
Significant roentgen findings	5 of 6 patients

The preoperative diagnosis was accurately made in 43 of the 51 cases (table 14). In the other eight cases ectopic pregnancy was suspected enough to result in celiotomy. The postoperative diagnosis at the time of surgery could not be certain in two cases until confirmed by microscopic examination. The pathologic diagnosis was not definitely established in four cases.

Table 14. — Diagnosis

	Ectopic Pregnancy	Pelvic Inflammatory Disease	Cyst	Appendicitis	Incomplete Threatened Abortion	Total
Referring diagnosis	26	6	8	4	7	51
Admission proved ectopic pregnancy	37	2	6	4	2	51
Operating room preoperative diagnosis	43	2	0	4	2	51
Postoperative diagnosis	49	1	1	0	0	51

Note: Pathologic change not definitely confirmed in four patients.

The patients in shock were all operated on immediately, but in those patients with less acute symptoms the delay had no bearing on the length of stay in the hospital after surgery was performed, nor on the outcome (table 15). No patients died.

In 31 of the 51 cases no preoperative surgical diagnostic measures were instituted (table 16). It is thought that each of the tabulated measures has its value in individual situations. Culdoscopy and hysterography are mentioned only to be condemned. Colpocentesis probably has its place in establishing the diagnosis, although in cases in which it would be of value, the diagnosis and necessary procedure are evident without it. The distaste of one of us (F.R.S.) for "needle surgery" has influenced somewhat the rare use of colpocentesis. Colpotomy is of definite value, but only if both tubes and ovaries can be exposed and visualized. In cases of ruptured ectopic pregnancy, the diagnosis is generally evident without it. While we confess to having successfully completed the removal of an ectopic gestation via the posterior colpotomy approach, it would seem to be a smug performance of "surgical calisthenics" and to belong to the distant past when an abdominal scar was considered to be a stigma.

Table 16. — Procedures Before Celiotomy

Procedure	Number of Patients
Dilatation and curettage only	15
Colpotomy only	2
Colpocentesis only	1
Dilatation and curettage and colpotomy	2
Culdoscopy	0
Hysterograms	0

At operation, coexisting pathologic conditions were present in 11 cases, in five of which there was chronic salpingitis. In two cases there was acute pelvic inflammatory disease, in one a hydrosalpinx and in the other inflammation resulting from self-induced attempted abortion. There were two cases in which a fibroid uterus was present. An acute infection of the bladder was present in one case.

A blood transfusion was administered in 29 cases; in 22, no blood was administered. The average amount of blood given was 1,000 cc., and

Table 15. — Time Factors

Days	At once	1	2	3	4	5	6	7	8	9	10	11	12	13	14	More Than 14	Total
Admitted to surgery	23	8	7	3	2	2	1	1	1	0	0	0	1	0	1	1	51
Surgery to discharge						1	1	10	7	6	8	4	1	7	1	5	51
Total hospital stay								1	5	9	8	5	6	1	7	9	51

Note: Longest hospital stay was 32 days.

the maximum amount to any patient was 2,500 cc. No autogenous transfusion was given.

In five cases there were postoperative complications. In two, paralytic ileus occurred; in one, an incompatible blood transfusion was given; in one, pulmonary edema occurred between the performance of dilatation and curettage and celiotomy, with a question later of pneumonia with wound infection; and in one, there was thrombophlebitis.

The status of the patient deteriorated in 14 cases during periods of observation, as evidenced by sudden shock, increased pain and/or bleeding, reduction of hemoglobin or hematocrit levels, and increased size, definiteness or tenderness of the abdominal mass. The deterioration was the indication for operation and the end of the period of observation. In these 14 cases, diagnosis when the patient was admitted to the hospital was probable pelvic inflammatory disease in four cases, incomplete abortion in four, threatened abortion in three, and ovarian cyst in three. The Friedman test gave negative results in four cases and was not reported at the time of operation, although the reaction was positive, in three other cases. In four cases dilatation and curettage were inconclusive, and in two cases the patient was allowed to go home to return six to eight days later with the diagnosis of ruptured ectopic pregnancy quite evident. In one of these cases colpocentesis gave a negative result at the time of the dilatation and curettage.

Comment

Our plan of management has been to operate in cases of definitely diagnosed ectopic pregnancy, with blood replacement when diagnosed. In cases with questionable diagnosis, additional diagnostic measures should be utilized or considered. Hemoglobin, erythrocyte count, leukocyte count and hematocrit determinations are all important tests for evaluation of the patient's status as well as helpful diagnostic aids. Roentgenograms with the patient in the supine position have been found to be of greater value than we had supposed. Colpotomy has been favored over colpocentesis. Culdoscopy has not been used on patients with suspected ectopic pregnancy. Perhaps it could be used to advantage in certain situations (and is used in our clinic in other situations) because none of our four cases of unruptured ectopic pregnancy were accurately diagnosed preoperatively. We have preferred colpotomy with visualization of the tubes or exploratory laparotomy. Additional elective surgery has usually been deferred.

Summary and Conclusions

An analysis of 51 cases of ectopic pregnancy has been made as to diagnosis, behavior and management.

The predominant symptoms are pain and bleeding of some sort. The influence of previous or coexisting genital infection on the incidence of ectopic pregnancy cannot be denied. Primary infertility seems to play a minor role.

There is no routine preoperative program of procedures. Instead, cases are individualized and necessary measures instituted.

In cases of questionable diagnosis, additional tests should be utilized. The value of these tests has been discussed.

Complications and time factors have been stated.

There were no deaths in this series.

It is suspected that the increase in incidence of ectopic pregnancies is apparent rather than factual.

If observation is elected in doubtful situations, the observers must be constantly alert for signs of deterioration of the patient's status.

In a case of suspected ectopic gestation, perform a celiotomy with accurate and adequate visibility if there is any doubt.

The management is celiotomy with blood replacement when ectopic pregnancy is diagnosed.

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Carcinoma of the Esophagus

Study of Fifty-Five Cases at Duval Medical Center in Past Eight Years

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The increasing incidence of carcinoma of the esophagus in recent years has made it a disease of increasing importance to everyone. There have been 55 cases of carcinoma of the esophagus diagnosed and treated in the Duval Medical Center Tumor Clinic during the past eight years. All of these were proved histologically, and have been followed to the present date or to the date of the patient's death. Although this institution does not have records that represent the incidence of the disease prior to our present series, official mortality records of the United States Public Health Service[1] reveal that the disease is increasing in frequency. The reported deaths from carcinoma of the esophagus in the years 1934-1944 increased approximately 30 per cent. During this period there was not a corresponding increase in carcinoma of the stomach and duodenum. Carcinoma of the esophagus now ranks ninth in frequency in the malignant diseases of the white male.[1]

This malignant condition is primarily a disease of the aging and elderly person. In our series 87 per cent of the patients were over 50 years of age; 67 per cent were in the sixth and seventh decades. The over-all age range was 23 to 88 years. This incidence closely parallels that in 794 cases collected by DeBakey and Ochsner.[2] The reported incidence in their Charity Hospital series was 85 per cent over 50 years and approximately 70 per cent in the sixth and seventh decades.

Table 1. — Age Incidence

Age Group	Patients	Per Cent
2-29	1	2
30-39	2	4
40-49	4	8
50-59	19	34
60-69	18	33
70-79	8	13
80-89	3	6

From the Department of Surgery, Duval Medical Center, Jacksonville.

The racial incidence of the disease in this series was 41 Negro patients and 14 white patients. This figure parallels the racial ratio in the hospital admissions at Duval Medical Center. In other reported series there is little if any significant racial difference.[3]

There were 41 males and 14 females in the series, a ratio of 3:1. In the series reported by Brown[3] the ratio was 29:21, and in that of DeBakey and Ochsner[2] the males outnumbered the females 2:1.

Table 2.— Race and Sex Incidence

Race	Patients
Negro	41
White	14
Male	41
Female	14

Anatomically, this malignant lesion is located primarily in the thoracic portion of the esophagus, although it may occur in the cervical and abdominal segments. In our series 12, or 22 per cent, occurred in the upper third of the esophagus; 25, or 45 per cent, in the middle third and 15, or 27 per cent, in the lower third. This distribution closely corresponds to that reported in other collected series.[2,3]

Table 3. — Site of Lesion

Location	Patients	Per Cent
Upper third	12	23
Middle third	25	45
Lower third	15	27
Not in records	3	5

The figures in table 3 are of considerable therapeutic and prognostic significance, since lesions of the lower portion of the esophagus lend themselves more satisfactorily to surgical procedures and have a higher rate of resectability. Histologically, carcinoma of the esophagus may be divided into two types: adenocarcinoma, which is comparatively infrequent, and epidermoid carcinoma, which predominates. No case in which adenocarcinoma was continuous with gastric mucosa is included in our series. In all, epi-

dermoid carcinoma occurred in 93 per cent of the cases and adenocarcinoma in 7 per cent. This is a lower incidence of adenocarcinoma than is reported in other series.

The onset of symptoms is insidious. The symptoms may mimic diseases of other systems and may not seem important to the patient or even to the physician first consulted.[4] In our series the predominately appearing initial symptom was a mild dysphagia, which was disregarded by the patient, who seemed only vaguely aware of this symptom at onset. This neglected symptom was noted early in the disease by 75 per cent of the patients. In all cases it was discounted by the patient and in some cases treated symptomatically with belladonna alkaloids, which often produced temporary improvement. The initial delay on the part of the patient and even the physician in some cases is certainly a large factor responsible for the poor survival rates in carcinoma of the esophagus.[5]

In table 4 one may note the surprisingly long duration of symptoms directly related to the malignant disease. In 17 cases symptoms had been present for more than six months.

Table 4.— Symptoms of Carcinoma of the Esophagus

Symptom	Per Cent	Period
Dysphagia	75	3-21 months
Pain	16	1-2 months
Pain in chest	11	
Pain in abdomen	7	
Vomiting	7	2 weeks
Hoarseness	0.5	1 month

It is apparent that the average patient is in a far advanced stage of the disease when he first presents himself for diagnosis and therapy. In this fact lies the key to the currently poor survival rate, and at the same time early diagnosis presents the greatest hope for improvement of the discouraging cure rate.[7] It is well established that after this lesion is suspected, there is little difficulty in making a positive diagnosis by use of esophagography and esophagoscopy. These studies will usually confirm or exclude the presence of carcinoma. Palmer,[8] in presenting an analysis of 14 failures to prove a histologic diagnosis in 100 patients, sketched the intramural spread of carcinoma and clearly demonstrated how the lesion could obstruct the lumen and still remain inaccessible to the biopsy forceps. In our series we were able to establish the diagnosis in 80 per cent of the cases. In seven cases the results of the biopsy were negative on the first attempt and in two of these were negative despite a second biopsy.

The therapy of choice and the only hope for cure in carcinoma of the esophagus is surgical extirpation.[2] Any other therapeutic measure is purely palliative. Table 5 clearly demonstrates

Table 5. — Results of Therapy

	Cases	Per Cent
Operated	19	33
Inoperable	27	50
Curative	5	31
Resectable	16	80
Nonresectable	4	20
Palliative	11	69
Not operated on for reasons other than inoperability	9	16

that although the results of treatment, both operative and nonoperative, were extremely poor, the only cures and better palliation were produced by surgical extirpation of the diseased tissue. In our series the lesion was classified as inoperable if there was distant metastasis, invasion into the bronchus, or tracheobronchial fistula. In 27 cases it was pronounced inoperable by these criteria. Two of the patients refused surgery. Induction of anesthesia was stopped before surgery began in one case because the patient was doing so poorly. Reaction to cocaine during the bronchoscopic examination caused fatal termination in one case. In five cases the patient was not cleared by the medical department because of the presence of other diseases.

In nineteen of the cases the lesion was thought to be operable and was explored. In three of these the surgical measures were open and close procedures. In the other 16 the lesion was resected, and esophagogastrostomy was performed; in five of the 16 the surgical procedure was believed to be curative. Of the patients in these five cases, two are living without recurrence, one four years after and one five and one-half years after the initial procedure. The one who is a four year survivor has been followed closely and has severe esophagitis requiring repeated dilation. The one who is a five and one-half year survivor had a supraclavicular node dissection nine months after the initial procedure. This case was reported by Day[9] elsewhere and needs no further comment here. Of the other three who had curative procedures, one survived 13 months and died following recurrence. The other two died in the immediate postoperative period of complications following surgery. Of the 11 who had palliative procedures, eight died in the immediate postoperative period

of complications. The other three survived five months, three months and one month, and all had residual disease with extension of the malignant process at death.

Table 6. — Causes of Death

Cause	Patients
Hemorrhage and shock	4
Pulmonary edema and shock	3
Cardiac arrest	2
Rupture of diaphragm	1

In our series the average time lapse from onset of symptoms to diagnosis was 6.8 months; the time lapse from diagnosis to death was 5.6 months. The longest survival periods were five and one-half years and three and one-half years. One patient had roentgen therapy and is living 21 months after diagnosis, and one patient had only dilation and lived 20 months. Another patient received no specific therapy and lived 14 months; still another had roentgen therapy and lived 13 months. These cases are too few, however, to warrant any conclusions and represent our extremes. Raven[6] reported that of patients treated with roentgen rays 30.6 per cent were dead within three months, and 55 per cent were dead within six months. He had one patient, however, who lived four years after receiving roentgen therapy. Of the 11 patients treated with roentgen therapy, one is still living 20 months after diagnosis, although she has an esophagotracheal fistula, which has been demonstrated by dye studies. Excluding the one living 21 months, the average survival time was four and one-half months; and, if that one is included, the survival time was six months (table 6). This period is longer than that for the entire series, including the ones who had curative surgery. Six of these patients were improved on roentgen examination with barium swallow.

Three of the patients who were subjected to gastrostomy for obstruction could take solid food following roentgen therapy. In three of these patients no improvement was noted. Two of the patients survived too short a time to evaluate the therapy. Fifteen patients underwent gastrostomy, the Spivak, Witzel and Janeway technics being employed. One patient on whom a jejunostomy was performed was lost to follow-up. All patients who were subjected to gastrostomy were able to be discharged from the hospital. The average time between gastrostomy and death was three and one-half months. The indications used for gastrostomy were inoperability, severe pain associated with obstruction and fistula between the esophagus and tracheobronchial tree. In all patients who experienced severe pain, the pain on swallowing was less after surgery. All the patients with obstruction complained of being unable to swallow saliva, but adjusted to this trouble a few weeks after gastrostomy.

Merendino and Mark[10] reported 10 per cent fistula formation in 100 cases of carcinoma of the esophagus. In four cases in our series fistulous tracts developed between the esophagus and the tracheobronchial tree; three communicated with the trachea and one with the left bronchus. All were proved by roentgen dye studies. One patient lived two weeks, and one lived five weeks after the fistula was demonstrated. In one case the fistula has been present for six months, and the patient is still living. She has had roentgen therapy and also has a gastrostomy, through which she takes all nourishment and fluids.

In three of our cases diverticula were demonstrated on roentgen examination. It was the roentgenologist's impression that all were of the pulsion type, and all were in the upper third of the esophagus. In all there was obstruction, and gastrostomy had been performed. One patient lived 20 months, one lived eight months, and one lived only two weeks. The duration of symptoms before diagnosis was 12 months, 15 months and six weeks in the three cases, respectively.

Summary and Conclusion

A clinical review of 55 cases of histologically proved carcinoma of the esophagus is presented.

This malignant lesion occurs predominately in elderly persons and is more frequent in the male.

The carcinoma is located predominately in the middle third and lower third of the esophagus. This fact should tend toward a higher rate of resectability, therefore a higher rate of cure.

Ninety-three per cent of the lesions in the series were epidermoid carcinoma; 7 per cent were adenocarcinoma.

The urgent need for earlier diagnosis is clearly demonstrated. The insidious onset of the disease and neglect of ominous symptoms are reviewed.

The operative rate was 33 per cent and the rate of resectability 80 per cent. The mortality rate was 65 per cent for cases with resection, although the majority of resections were thought to be palliative procedures. The operative mortality was inordinately higher for this group than for those in series reviewed. It is concluded from this report that in most of the cases the operative

risk was poor and improvements in preoperative evaluation and postoperative management made in recent years would reduce this figure markedly.

The use of palliative roentgen therapy seems to be of value in relieving obstruction and possibly increasing longevity.

Of the 55 patients only two survived without disease. These two were treated by adequate surgical removal, and represent a four and five year survival.

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Syphilis in Polk County

Report of 1955 Blood Testing Survey

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During the past years the Florida State Board of Health in cooperation with local County Health Departments has been conducting intensive selective mass blood testing surveys in those areas of the state where it is believed there is an appreciable amount of undetected syphilis. Polk County, as a highly populated industrial and agricultural county with a population of approximately 31,000 Negroes, was thought to be such an area. No previous intensive survey had been conducted in the county. Many of the agricultural and industrial employees had not been tested in routine programs of the Health Department. The decision was made, therefore, with the approval of the Polk County Medical Association, to conduct an intensive serologic survey among suspected high incidence groups. Such groups included low income Negroes, migrant agricultural workers and low income white workers.

Survey Program

The blood samples were drawn in predominantly Negro and low income white areas, to include as many persons as possible in these suspected high incidence groups. In each community one station was located in a white business district to help direct public attention to the program. In advance of the survey the project supervisor and a health department physician met with prominent persons in the Negro communities and a few white officials. These meetings were held in each of the five main communities in the county. At this time the reasons for the survey and the methods of conducting the survey were discussed. A motion picture on syphilis was shown, and any questions about the disease or the survey were answered. Medical questions were answered by the physician from the health department. In addition to the publicity obtained by the community meetings, posters were placed throughout the area indicating the dates of the survey, and radio and newspaper announcements gave the times and places for each blood testing station.

Each testing station was staffed by a nurse and a clerk. A sound truck traveled through the testing areas prior to and during testing hours. The truck used records and announcements to attract the attention of the residents in the area, and informed them of the station location. The testing stations were designed to be simple and

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easily portable. They consisted simply of a folding table, two chairs, and signs and posters advising the public to have a blood test. Stations were located near business establishments where people would normally tend to congregate and where lighting conditions were favorable for work at night. Testing hours were from 4 to 8 p.m., Tuesday through Friday, and 10 a.m. to 4 p.m. on Saturday.

Blood samples were drawn with the Sheppard-Keidel vacuum tube. This was chosen because it is a self-contained sterile unit, eliminating the necessity of presterilization and repeat sterilization of syringes and needles.

Serologic testing was performed by the branch laboratory of the State Board of Health in Tampa. All specimens were tested by the VDRL qualitative method, and if positive, by the VDRL quantitative test.

All patients with positive or weakly positive reactions to serologic tests, with the exception of those already being followed by the Polk County Health Department, were asked to report to one of the seven Health Department offices throughout the county. Except for 18 patients who were examined by their personal physician, all patients were examined in one of the Health Department offices. Reports from the private physicians who examined these 18 patients are included in this report.

Suspects examined in the clinic of the Polk County Health Department were given a physical examination, and a complete history referable to syphilis was taken. Records of previous examinations, serologic tests for syphilis, and treatment were available on a number of suspects. These records were obtained from the Polk County Health Department, other Health Departments, hospitals, and private physicians. Information from the history, physical examination, and previous records was correlated to arrive at as accurate a diagnosis as possible. In those cases with the history and physical examination giving negative evidence, further serologic tests were made. In some cases monthly serologic tests were performed for six months. In those cases in which a biologic false positive reaction was considered, treponema pallidum immobilization (TPI) tests were made. While there are many causes for acute and chronic biologic false positive serologic reactions, few if any nontreponemal diseases cause a positive TPI test. In this survey, a false positive serologic reaction was diagnosed in 48 suspects.

Results of Survey

Between Sept. 8, 1955, and Oct. 16, 1955, 6,273 blood specimens were drawn and tested. Of these, 387 gave a positive and 153 a weakly positive reaction, a positivity rate of 8.6 per cent. Of the suspects 533 were Negroes and seven were white. A total of 515 persons was evaluated, or 95.4 per cent of the suspects. Table 1 gives the disposition of the suspects. Table 2 gives the diagnoses of those suspects found to be infected. Ten had early latent and 343 late latent syphilis, 13 cardiovascular syphilis, 66 neurosyphilis, one late cutaneous syphilis, and 38 congenital syphilis.

Table 1. — Disposition of Suspects

DISPOSITION	NUMBER
Not located	19
Uncooperative	6
Infected	467
Not infected	48
Total	540

Table 2. — Diagnoses of Infected Suspects

STAGE OF INFECTION	NUMBER
Early latent	10
Late latent	343
Cardiovascular	11
Neurosyphilis	64
Late cutaneous	1
Congenital	38
Total	467

Of those patients who were infected, 152 had had no previous treatment, 153 had never had adequate treatment, and only 162 had been adequately treated. Table 3 gives the diagnoses and treatment status of those suspects found to be infected. It is worthy of note that 12 patients with congenital syphilis had never been treated. These patients had never been examined for congenital syphilis even though in many cases the mother had been treated for syphilis after the patient's birth or siblings had been treated for congenital syphilis.

Table 3. — Diagnoses and Treatment Status of Infected Suspects

STAGE OF INFECTION	NO PREVIOUS TREATMENT	PREVIOUS INADEQUATE TREATMENT	PREVIOUS ADEQUATE TREATMENT
Early latent	9	0	1
Late latent	99	123	121
Cardiovascular	5	2	4
Neurosyphilis	26	22	16
Late cutaneous	1	0	0
Congenital	12	6	20
Total	152	153	162

An attempt was made to make spinal fluid examinations on all patients who had been previously inadequately treated before beginning a

course of treatment. Spinal fluid examinations were performed on 89 patients. Table 4 shows the results of these examinations. In 79 the reactions were negative, in six they were positive but inactive, and in four they were positive and active. Old clinic or Rapid Treatment Center records provided an additional 77 spinal fluid examinations. Of these, in 62 the reactions were negative, in 12 they were positive but inactive, and in three they were positive and active. An additional 43 patients said they had had spinal fluid examination in the past and were told they were "all right," but no records were obtainable. All patients being treated for the first time and all patients with clinical neurosyphilis will have spinal fluid examinations one year after treatment.

Table 4. — Results of Spinal Fluid Examinations

Examination Result	Number
Negative	79
Positive, inactive	6
Positive, active	4
Total	89

It is evident that the survey detected predominantly late latent syphilis. In 73.4 per cent of the suspects found to be infected, late latent syphilis was present. No primary or secondary syphilis was found. Sex contacts of all patients with early latent syphilis were examined, and one case of secondary syphilis was found. Other contacts were out of the county, and reports have not as yet been received regarding their diagnoses.

The principal value in a survey of this type is the detection of previously unknown and inadequately treated syphilitic persons, and bringing or returning them to treatment. In this survey, 305 syphilitic patients were brought or returned to treatment. In addition, the survey was believed to be of educational value in acquainting the physicians and lay persons with the prevalence of syphilis in the county.

Summary

Of 6,273 serologic tests for syphilis, 540 (8.6 per cent) gave positive or weakly positive results.

Of the suspects, 515 (95.4 per cent) were evaluated, and 467 (90.7 per cent) of those evaluated were presumed to be infected with syphilis as a result of the correlation of the history, physical findings and laboratory studies.

Of the 467 presumably having syphilis, 305 (65.3 per cent) had either received no previous treatment or had been inadequately treated.

Of the 515 suspects evaluated, in 48 (9.3 per cent) a false positive serologic reaction was diagosed, largely by means of clinical findings giving negative evidence and a negative reaction to the Treponema pallidum immobilization test.

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Virological Findings on Polio and Polio-Like Diseases—1956

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The Virus Diagnostic Laboratory was opened officially in November 1955. The purpose of the laboratory is to aid physicians in the differential diagnosis of viral and rickettsial infections. Another function of the laboratory is to furnish information to the health officers about the occurrence of previously recognized as well as heretofore unrecognized infections in their respective communities and areas. A third function of the laboratory is the furtherance of training at the undergraduate and graduate levels. During the past 18 months, the laboratory services have been utilized by physicians in Dade, Broward and Monroe counties, as well as by hospitals and other agencies in several countries of the Caribbean.

One of the contributions made during this period of time was the provision of information in the area of differentiation between the many causes of polio-like diseases. The breakdown of the findings for 1956 is shown in tables 1 to 4. Virus isolation was performed in strain HeLa cells (derived from human carcinoma of the cervix) and in monkey kidney cells grown in tissue culture. Preliminary identification of the isolated agents was based on the nature of the cytopathogenic changes. Final typing was accomplished by the neutralization test in tissue culture tubes. The tests on patients' serums included neutralization tests, a few complement fixation tests with polio antigens and, whenever indicated, complement fixation tests with lymphocytic choriomeningitis, eastern equine encephalitis, St. Louis encephalitis, mumps, Coxsackie B and adenovirus antigens.

Table 1 is based on results obtained from specimens provided by patients who had not received vaccine. The most important feature of this table is the finding that whereas 21 out of 27 (80 per cent) paralytic patients yielded the classical types of poliovirus only a relatively small number of nonparalytic patients yielded these viruses (8 per cent). APC (adeno) viruses and ECHO* viruses were recovered each from one patient. The causal relationship between these viruses and diseases is not fully understood and is currently the subject of research. In the majority of nonparalytic patients no etiologic agent was demonstrated either by isolation technics or by antibody studies. This finding indicates that a large portion of nonparalytic patients may be infected with agents whose nature is yet unknown and may conceivably include new types of poliovirus.

In tables 3 and 4 are shown the results of laboratory tests in patients who received one, two and three injections of poliovaccine. The numbers are too small to allow a definite conclusion regarding the effectiveness of the vaccine. All that can be said at this time is that seven paralytic cases occurred among patients who had previously received one or two injections. Five of these yielded poliovirus in their stool, and there was only one paralytic mild illness, in a patient who had received all three injections. This patient yielded no virus, and it is possible that his illness was not due to poliovirus.

Table 4 illustrates that not infrequently mumps virus may cause a clinical picture resembling nonparalytic poliomyelitis.

The findings here reported represent the beginning of the operation of the Virus Diagnostic Laboratory. It is hoped that continued efforts in this undertaking will help to explain and clarify such questions as the etiology of some of the polio-like diseases, the importance of poliovirus in the occurrences of aseptic meningitis and the effectiveness of vaccine against polio. As more and more people become immunized, the medical profession may witness the occurrence of many illnesses which, while resembling polio, especially the nonparalytic variety, may actually be caused by numerous other agents. The Virus Diagnostic Laboratory could therefore become increasingly

From the Virus Diagnostic Laboratory of the Variety Children's Hospital and the University of Miami School of Medicine.

*Enteric Cytopathogenic Human Orphan Viruses.

Table 1. — Patients Who Had Not Received Vaccine
Virus Isolation Findings

Form of Disease	Total Number	Number Tested	Polio Type I	Polio Type II	Polio Type III	Other Viruses	Negative	Per Cent Positive for Poliovirus
Fatal	1	1					1	
Bulbar	3	3		2			1	66
Bulbospinal	2	1					1	
Paralytic	36	27*	12	8	1		6	80
Nonparalytic	41	36	2		1	1 adeno** 1 ECHO†	31	8
Miscellaneous	13	11					11	0
Total	96	79	14	10	2	2	51	33

* Two additional patients were tested; the results suggested the presence of poliovirus, but were inconclusive.
** Formerly designated adenoidal pharyngeal conjunctival virus.
† ECHO, enteric cytopathogenic human orphan virus.

Table 2. — Patients Who Had Not Received Vaccine
Serologic Findings on Patients From Whom Virus Was Not Isolated

		Tests with Polio Antigens*					Tests with Neurotropic Virus CF Battery**	
Form of Disease	Number Tested	Polio Type I	Polio Type II	Polio Type III	Polio UT†	Negative	Number Tested	Negative
Bulbospinal	2	2	0	0	0	0	0	
Paralytic	6	1	1		2	2	0	
Nonparalytic	19	0	0		13	6	29	29

* With few exceptions, this was the neutralization test.
** Includes: LCM, EEE, St. Louis encephalitis, mumps, Coxsackie B and adenovirus antigens.
† UT, infection at undetermined time, not necessarily recently.

Table 3. — Patients Who Had Received Polio Vaccine
Virus Isolation Findings

Form of Disease		Total Number	Number Tested	Polio Type I	Polio Type II	Polio Type III	Other Viruses	Negative
One Injection	Paralytic	3	2		1			1
	Nonparalytic	5	3					3
	Miscellaneous	2	1					1
Two Injections	Bulbospinal	1	1	1				
	Paralytic	3	3	1		2		
	Nonparalytic	10	8					8
	Miscellaneous	1	1					1
Three Injections	Paralytic	1	1					1
	Nonparalytic	4	3					3

Table 4. — Patients Who Had Received Polio Vaccine
Serologic Findings on Patients From Whom Virus Was Not Isolated

		Tested with Polio Antigens						Neurotropic Virus CF Battery		
	Form of Disease	Number Tested	Polio Type I	Polio Type II	Polio Type III	Polio UT	Negative	Number Tested	Positive	Negative
One Injection	Paralytic	0						0		
	Nonparalytic	3			1	2		5		5
	Miscellaneous	0						2	1 (mumps)	1
Two Injections	Paralytic	0						0		
	Nonparalytic	5				3	2	9	1 (mumps)	8
	Miscellaneous	1				1				
Three Injections	Paralytic	1				1		1		1
	Nonparalytic	0						4	3 (all mumps)	1

helpful in aiding the physician to arrive at a differential diagnosis.

As an additional service the Laboratory is currently accepting, at physicians' request, serum from normal persons wishing to know whether they possess antibodies to polio and mumps viruses. For the convenience of physicians we are reproducing instructions for submission of specimens.

We wish to thank Dr. T. E. Cato, Dade County Health Officer, Dr. G. Erickson, Dade County epidemiologist, and the many physicians who submitted specimens to the laboratory for their excellent cooperation and help.

Mail or Deliver Specimens to VIRUS DIAGNOSTIC LABORATORY

Variety Children's Hospital
6125 S. W. 31st Street
Miami, Florida
MOhawk 1-5391

Instructions for the Collection of Specimens for Virus and Rickettsial Diagnosis

The Virus Diagnostic Laboratory is prepared to aid in the diagnosis of the following diseases:

Viral meningitis	Herpangina	Lymphogranuloma venereum
Encephalitis	Pleurodynia	Smallpox
Poliomyelitis	Influenza	Vaccinia
Mumps	Q Fever	Pharyngoconjunctival fever
Herpes simplex	Psittacosis	Measles

In addition, the laboratory may on occasion accept specimens on a research basis for studies on diseases of unknown etiology. Routine tests are also performed for typhus, Rocky Mountain spotted fever and rickettsial pox.

All specimens must be accompanied by a history either in the nature of a carbon copy of the hospital history or in the form of a special history sheet obtainable from the laboratory.

With few exceptions, laboratory diagnosis may be secured from an examination of paired serum specimens, one to be taken in the acute phase of illness and the other two weeks later. Such serums may be sent by first class mail—in regular mailing tubes—provided they are not contaminated.

Under some circumstances, such as when a diagnosis of rickettsial diseases, psittacosis or lymphogranuloma venereum is suspected and antibiotic therapy has been administered, it may be necessary to obtain a later specimen inasmuch as antibodies to the etiologic agents of these diseases may be suppressed for a time by the therapy.

All serum specimens *must be sterile* and submitted in sterile tubes sealed with sterile stoppers. Adhesive tape should be wound around the stoppers.

The exceptions in which *serum* specimens are *inadequate* are: poliomyelitis, pharyngoconjunctival fever, pleurodynia, herpangina, herpes simplex, measles, smallpox and vaccinia. For these it is necessary to have specimens as indicated:

Poliomyelitis—stool† and paired serum specimens

Pharyngoconjunctival fever—throat washing*—paired serum specimens

Pleurodynia—throat washing† and/or stool† and paired serum specimens

Herpes simplex—material from lesion* and paired serum specimens

Herpangina—throat washing† and/or stool† and paired serum specimens

Smallpox and vaccinia—material† from the lesion and paired serum specimens

Measles—throat washing* and stool* and paired serum specimens.

Although serum specimens are adequate for diagnosis for most of the other types of illnesses, it may sometimes be appropriate and occasionally necessary to send specimens for virus isolation in the following diseases:

Conjunctivitis—eye wash* and paired serum specimens

Influenza—throat washing* and paired serum specimens; in both instances, the washing may be obtained with sterile broth, sterile milk or sterile water.

Viral meningitis—spinal fluid,* stool* and paired serum specimens.

Single serum specimens are of considerably less value than paired serum specimens. If and when it is not possible to obtain an early acute phase serum, a single specimen of convalescent serum will be accepted for testing.

Information about special problems including "viral" myocarditis, cytomegalic inclusion disease, unclassified diseases, or other viral problems may be secured by contacting Dr. M. Michael Sigel, University of Miami School of Medicine, Highland 3-4633, extension 32, or Virus Diagnostic Laboratory, Variety Children's Hospital, MOhawk 1-5391, extension 40.

* Should be sent either by messenger or by first class mail in frozen condition.

† May be sent by first class mail without freezing if dry ice is not available.

All specimens * † for virus isolation must be sent to the laboratory as soon after taking as possible. A delay will decrease the likelihood of virus isolation. Freezing of serum specimens for routine work is not necessary. They may be sent by first class mail.

For immunity studies 3 cc. of serum is required. For diagnostic tests 5 cc. is needed.

ABSTRACTS

A Cytochemical and Cytomorphological Orientation of Intraepithelial Carcinoma of the Cervix Uteri. By Alvan G. Foraker, M.D. Acta Union Internationale Contre le Cancer 12:74-79, 1956.

In this study, as measures in orienting intraepithelial carcinoma with respect to frank invasive carcinoma and to non-neoplastic cervical lesions, dehydrogenase localization, measurement of nuclear size and photometric estimation of hyperchromatism were investigated. Through these procedures additional information was sought concerning the currently doubtful relationship of intraepithelial carcinoma to invasive cervical carcinoma. The materials and methods are described and the results set forth in tables. It is concluded that with the methods used in studying different properties of squamous epithelium, each relating in some manner to cell growth, intraepithelial carcinoma conforms closely to invasive carcinoma as regards dehydrogenase activity, mean nuclear size, nuclear-cytoplasmic ratio and hyperchromatism.

Renal Revascularization by Splenic Artery Implantation. An Experimental Study. By H. Clinton Davis, M.D., and Irwin S. Morse, M.D. A. M. A. Arch. Surg. 75:13-16 (July) 1957.

This study was undertaken to determine the adequacy of the Vineberg principle of arterial implantation for collateral circulation on the kidney, inasmuch as this organ is more easily studied than either the heart or the liver. The ease with which the blood supply of the kidney can be controlled, and function studies performed, makes the kidney the organ of choice in evaluating the effectiveness of arterial implantations for collateral circulation. The technic employed and the results obtained are described.

Observations on five dogs in which the splenic artery was implanted into the left renal cortex showed some splenorenal collateral circulation, which was most effective in a kidney which had been rendered partially ischemic by ligation of a branch of the left renal artery. Volume flow studies, attempted in the six month waiting period, suggested that the amount of collateral flow was small in the nonischemic kidney.

Determination of Bacterial Sensitivity, an Office Procedure. By L. P. Carmichael. Postgrad. Med. 20:26-28 (Oct.) 1956.

Increasing bacterial resistance is resulting from the widespread use and abuse of antibiotics. This fact, coupled with patient sensitivity to antibiotics and the number of chemotherapeutic agents now available, has made the determination of correct agents to use in infection a matter of prime importance. Culture of the offending organism in determining its sensitivity to antibiotics, once an involved laboratory procedure, can now be done simply and quickly in any physician's office, this author reports. He describes a simple but effective incubator, constructed from a wooden box, and the additional equipment required for carrying out this test as an office procedure. Little time or material is invested in this method, and the cost to the patient is no more than that of the usual laboratory procedure. A case is reported which illustrates the usefulness of this method.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 241, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

A PRAYER FOR PHYSICIANS

ALMIGHTY AND EVER CREATING GOD, FROM WHOM WE COME AND TO WHOM WE RETURN, WE BOW IN AWE BEFORE THE MYSTERY OF LIFE WHOSE SOURCE AND SECRETS ARE IN THY KEEPING. WE THANK THEE FOR ALL THOSE THY SERVANTS WHO ARE WORKERS TOGETHER WITH THEE IN SAVING AND STRENGTHENING THE LIFE WHICH THOU HAST GIVEN UNTO US. AT THIS SEASON OF THE GREAT PHYSICIAN'S BIRTH WE PRAISE THEE FOR THE NOBLE PROFESSION WHICH HAS CARRIED THE MINISTRY OF HEALING ACROSS ALL BOUNDARIES OF RACE AND NATION AND CREED.

WE PRAY O GOD, THAT THOU WILT GUIDE WITH THINE INFINITE WISDOM THOSE TO WHOSE CARE WE ENTRUST OUR MINDS AND BODIES IN THE CRISES OF LIFE. ILLUMINE THE INSIGHTS TO DISCOVER CAUSES AND MAKE DECISIONS, WHEN LIFE HANGS IN THE BALANCE. GIVE POISE TO MEET THE UNEXPECTED AND PATIENCE TO ENDURE THE TEDIOUS. ENDOW OUR DOCTORS, WE BESEECH THEE, WITH THAT ABOUNDING HEALTH OF MIND WHICH IMPARTS COURAGE TO THOSE WHO SUFFER AND QUICKENS HOPE IN HEARTS THAT ARE FAINT. BE THOU THE GOOD SHEPHERD TO THE HEALERS WHO ARE CALLED SO OFTEN TO WALK THROUGH THE VALLEY OF THE SHADOW OF DEATH THAT THEY MAY LESSEN FEAR AND STRENGTHEN FAITH.

OUR FATHER, WE ARE PROFOUNDLY GRATEFUL FOR THE HIGH STANDARDS WHICH HAVE ENNOBLED THE HEALING PROFESSION, AND WE PRAY THAT ALL WHO PURSUE IT MAY FIND INNER SATISFACTION FROM ITS LOFTY SPIRIT OF SERVICE. KEEP ALIVE THE QUESTING EAGERNESS OF SCIENCE THAT CURES MAY BE FOUND FOR THE DREAD DISEASES WHICH STILL BAFFLE US. CONTINUE AND DEEPEN THE DESIRE TO SHARE THE SECRETS OF THE HEALING ART WITH ALL PEOPLES AND NATIONS THAT THE FORCES WHICH HELP MAY OVERCOME THE FORCES WHICH HURT AND THE CHRISTMAS PROMISE OF PEACE MAY COME TO EARTH. AMEN.

RALPH W. SOCKMAN

Ralph W. Sockman, D.D., Ph.D., is minister of Christ Church, New York, a prominent churchman, lecturer and author. He is a former president of Federation of Churches and Church Peace Union. Books by Doctor Sockman include "Higher Happiness," "How to Believe" and "The Whole Armor of God."

WRITTEN ESPECIALLY
FOR WHAT'S NEW

REPRINTED BY
PERMISSION OF
ABBOTT LABORATORIES

THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. Box 2411 Jacksonville, Florida

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The Voice of Reason

Frank G. Slaughter, M.D.

"That man no other man shall own,
Who to himself belongs alone."

So wrote Paracelsus nearly four hundred years ago. Yet the truth he managed to compress into two short lines of verse was never more important than it is today. Living in a state of tension and uncertainty, physical, economic and political, the minds of men and their actions are constantly swayed by conflicting urges and fears. The Russians toss a metal sphere called "sputnik" into space and a wave of hysteria sweeps over the world, the din of many voices presaging doom. So it was when we ourselves exploded the first atomic bomb over Hiroshima and the first mushroom cloud of a hydrogen blast rose above a Pacific atoll. So, too, did the croakers of doom foretell the destruction of mankind when the crossbow first came into use many centuries ago and when gunpowder sounded the doom of knights in armor. The truth is that weapons for mass destruction have been in men's hands since the first flint arrowhead was discovered and put into use. When the chips were down, so to speak, reason always prevailed over hysteria and it will undoubtedly do so again, but the world is obviously in for some troubled times unless the voices of reason speak louder than they have yet done.

"Just as the lily produces invisible perfume," Paracelsus also wrote, "so does the invisible body (the soul or mind) send forth its healing influence." He was speaking of physicians and how they should exert the steadying influence of their own sanity and certainty of purpose upon people under stress. Our modern mass media of communication serve to make one man's fears those of a hundred million people, if he has their ears and eyes through newspapers, television, and radio. The sound of voices on the air preaching doom today is literally as it was in biblical times on the tower of Babel when God did "there confound their language, that they may not understand one another's speech."

Were it possible to give a gift at Christmas to all the world, the most appropriate one might well be a brief period of aural nonfunction during which men would not be swayed by the voices

of doom inciting them to hysteria. Instead, they could listen then to the voice of reason within themselves. Failing that gift, however, hysteria should be treated by those best qualified to recognize and treat it, the physicians of the world. Come upon an accident shortly after it has happened and you find a scene of feverish confusion. Yet moments after a doctor arrives, reason is restored, not so much by what he does but because those confused have confidence in his ability to handle the emergency.

Hysterical symptoms can wreck the body so that, even when the cause is removed, permanent damage results. And this is no less true of the mistakes men make in the excitement of fear. Permanent damage can easily be done under the stress of intense emotion to our institutions, our government, even our religion, for we are all too easily drawn away from the teachings of Him whose birth we celebrate at this season. "Be not afraid of them that kill the body," said Jesus shortly before he went up to Jerusalem to be crucified. To kill a man's body is a single act, affecting him alone. But to kill a man's soul by depriving him of the power to reason logically because of fear can bring the same fate to many who listen and are swayed by him.

Individually and collectively, the voice of the medical profession is more respected than any other. But if we are to be heard, we must break out of our own snug nest of conformity, comfort and financial well-being. We must risk offending others by standing for order even when mob emotions erupt. Then more than ever, the calm voice of reason needs to be heard, as the voice of Jesus was heard nearly two thousand years ago, with the comforting message to those troubled by their own insignificance: "Fear not; you are of more value than many sparrows."

Editor's Note: The Journal is honored to have for the fifth consecutive year a guest editorial befitting the Christmas Season from the pen of Dr. Frank G. Slaughter, of Jacksonville, Florida's distinguished physician-author.

Whole Truths to Combat Misconceptions

The medical profession has progressed to the status of an art as well as a science. The medical man has manifested his importance in markedly increasing the longevity of life in preventive as well as curative medicine, and, until the last decade, has acquired a position of esteem, admiration and respect throughout the world.

The socialistic trend, however, during the last 25 years has somewhat altered this position. The opinion people have formed of the medical profession is partly the result of incomplete information as well as lack of information. Modern living no longer permits the intimate family and doctor relationship that existed in the "horse and buggy days."

The men and women of medicine adhere to great principles tested throughout long years, and today our tenets give us a bulwark of strength that has not failed. There are elements who would destroy the position occupied by Doctors of Medicine in those sectors remaining as a free world and whose efforts constitute a real threat. Popular opinion of the doctor has many facets, some justified, others unjustified. Our faults remain ours to correct, and this responsibility is an obligation of the medical profession.

One of our paramount duties and an obligation is to make an all-out effort to correct misunderstanding and misinformation fostered by half-truths presented through the press, whether in magazine articles or newspaper features. "As the Devil can quote Scriptures so can the Philosopher quote Science." Any corrective method used should manifest itself with supreme dignity and honesty.

Would it not be wise for the Florida Medical Association, as well as each component medical group, to have a special bureau which would provide a definite program of information to be disseminated by timely newspaper articles as well as individual speakers who appear before church groups, P.T.A. organizations, civic clubs, and other organizations? Much good can be accomplished by the presentation to the public of whole truths combating misconceptions of "wonder drugs," clarifying the title "Doctor" and its numerous connotations, explaining the care of the indigent as a service contributed by the profession, and providing a better understanding of demands made of men and women of the medical profession to meet ever higher standards. These are a few examples.

One of the best public relations approaches is for the doctor to take an active part in civic as well as political affairs. The inner sanctum of his office provides a focal point for each individual doctor to establish his own sphere of influence and make his personal contribution to the education of all.

Distinguished Florida Physician Sponsored for Highest National Office

Plans to present the name of Dr. Louis M. Orr of Orlando to the House of Delegates of the American Medical Association for consideration as President-Elect at the annual meeting of that association in San Francisco in June 1958 are of particular interest to every member of the Florida Medical Association. The letter announcing these plans, signed by Dr. Homer L. Pearson Jr., of Miami, the chairman of the Judicial Council of the American Medical Association, Dr. Reuben B. Chrisman Jr., of Coral Gables, and Dr. Francis T. Holland, of Tallahassee, Florida delegates to that body, and Dr. William C. Roberts, of Panama City, president of the Florida Medical Association, is published in this issue of The Journal It has been sent to all of the delegates and officers of the American Medical Association.

Born in Cummings, Ga., on Sept. 27, 1899, Dr. Orr received his academic and professional training in his native state. He was awarded the degree of Bachelor of Science in 1921 and the degree of Doctor of Medicine in 1924 by Emory University. There followed an internship at Peter Bent Brigham Hospital in Boston and a year's residency at Lakeside Hospital in Cleveland. He then entered the private practice of medicine in Orlando, and has continued to practice there since 1926. He limits his practice to urology.

Dr. Orr has through the years rendered faithful service to medicine both in Florida and in the nation. Since 1927 he has been active in the Florida Medical Association. In 1933, he became an Associate Editor of The Journal and has continued to serve in that capacity for a quarter of a century. In 1935 he was Councilor for his district. He was a member of the Committee on Venereal Disease Control in 1941, and chairman of the Committee of Review, Florida Medical Service Corporation in 1947. He served on the Advisory Board to the Executive Committee of the Florida Society of Medical Technologists in 1948 and on the Committee on Scientific Assembly and Specialty Group Problem in 1952. Since 1948, he has been a member of the Association's House of Delegates and for seven of the 10 years of this service he has served as chairman of the Credentials Committee. In 1954-55, he was a member of the Board of Governors. He is a prolific writer and has contributed many valuable scientific papers to The Journal as well as to national medical publications.

Also since 1948, Dr. Orr has represented the Florida Medical Association in the House of Delegates of the American Medical Association and in 1955 was elected its vice speaker. In addition, he has served the parent organization as chairman of the Federal Medical Services Committee and as a member of its Council on Medical Service. In 1953, he was chosen president-elect and in 1954 became president of the Conference of Presidents and Other Officers of State Medical Associations.

Dr. Orr is a member of the following medical societies: American Medical Association, American Association of Genito-Urinary Surgeons, American Urological Association, Southeastern Section of the American Urological Association, Southern Medical Association, Southeastern Surgical Congress, American College of Surgeons, Diplomate of the American Board of Urology, Association of American Physicians and Surgeons, and the International Society of Urology.

During World War II, Dr. Orr served as a colonel in the Medical Corps. From 1942 to 1945, he was the executive officer of the 15th Hospital Center in the European Theatre of Operations.

Among the many local activities with which Dr. Orr has been prominently identified through the years is the Civic Music Association of Orlando, of which he was president from 1939 to 1952. He has for some years also served as a trustee of Rollins College in nearby Winter Park.

Announcing Dr. Orr's Candidacy

Dear Dr. ————:

For several years an increasing number of delegates and other prominent members of the American Medical Association have urged that Louis Orr be presented to the House of Delegates for consideration as President-Elect. This we plan to do at the San Francisco meeting in June of 1958.

Since you know Louis' qualifications and capabilities, we respectfully request that you give your personal consideration to his continuing service to American Medicine.

Very cordially yours,

Homer L. Pearson Jr., M.D. Reuben B. Chrisman Jr., M.D.
Francis T. Holland, M.D. William C. Roberts, M.D., FMA, President

Laying of Cornerstone University Teaching Hospital

The cornerstone of the new Teaching Hospital of the University of Florida was laid on Oct. 26, 1957, in a simple ceremony presided over by Dr. J. Wayne Reitz, President of the University, as the second unit of the J. Hillis Miller Health Center now nears completion. In formally placing the mortar in the edifice for the cornerstone, Dr. Reitz used the trowel that was used in laying the cornerstone of the Medical Sciences Building, first unit of the Center, which was dedicated last year. Assisting Dr. Reitz in the ceremony were Mrs. J. Hillis Miller, widow of the late president of the University for whom the Center is named, Dean George T. Harrell Jr., of the College of Medicine, Dean Dorothy Smith of the College of Nursing, and Dr. Russell S. Poor, Provost of the Center.

Dr. Reitz presented the Medical Advisory Committee of Florida physicians who contributed



Dr. J. Wayne Reitz, President of the University of Florida, places mortar in the cornerstone while Dr. George T. Harrell Jr., Dean of the College of Medicine, observes.



Members of the Medical Advisory Committee of Florida physicians attending the ceremonies are shown left to right: Drs. William C. Thomas Sr., Gainesville; Chas. J. Collins, Orlando; Eugene G. Peek Sr., Ocala; David R. Murphey Jr., Tampa; William M. Rowlett, Tampa; Donald W. Smith, Miami, and Turner Z. Cason, Jacksonville. Attending but not shown are Drs. Clyde O. Anderson, St. Petersburg, and Edward Jelks, Jacksonville.

to the planning of the Center. The members of this committee who were in attendance were Dr. Clyde O. Anderson of St. Petersburg, Dr. Turner Z. Cason of Jacksonville, Dr. Charles J. Collins of Orlando, Dr. Edward Jelks of Jacksonville, Dr. David R. Murphey Jr. of Tampa, Dr. Eugene G. Peek Sr. of Ocala, Dr. William M. Rowlett of Tampa, Dr. Donald W. Smith of Miami, and Dr. William C. Thomas Sr. of Gainesville.

The building is scheduled for completion in time for use next September. The acceptance of in-patients in the fall of 1958 will coincide with the third year teaching schedule for the first classes of the College of Medicine and College of Nursing, enabling the students in these classes to begin their clinical training at that time.

The 400 bed Teaching Hospital will house outpatient clinics, a rehabilitation unit, a psychiatric floor and an ambulatory wing, which is a new concept in patient care. These facilities are in addition to those set aside for general hospital care of acutely ill patients. According to Dean Harrell, patients will be admitted by referral from the local family physician. He will decide whether the patient needs the specialized services of the Health Center or can be better cared for locally and he will remain in charge of the patient's care all year round.

Midwinter Seminar Ophthalmology and Otolaryngology Miami Beach, Jan. 27 - Feb. 1, 1958

The University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held in Miami Beach again this season. This twelfth annual meeting will convene on January 27 and continue through February 1. The Americana Hotel, the newest hotel on the ocean front, has been chosen for the meeting place. All of its facilities, including the beach and swimming pool, will be available to all registrants of the Seminar and their families. The schedule has been arranged to allow plenty of time to enjoy the exceptional vacation facilities of Miami Beach. The hours for all meetings are 8:30 a.m. to 1:30 p.m.

On January 27, 28 and 29, the lectures on Ophthalmology will be presented. The lecturers will be Dr. Frank D. Costenbader of Washington, D. C., Dr. John H. Dunnington of New York City, Dr. Peter C. Kronfeld of Chicago, Dr. W. Howard Morrison of Omaha, and Dr. C. L. Schepens of Boston.

The lectures on Otolaryngology are scheduled for January 30 and 31 and February 1. The lecturers will be Dr. Aram Glorig of Los Angeles, Dr. Jerome Hilger of St. Paul, Dr. Alexander S. McMillan of Boston, Dr. Samuel Martin of Gainesville, and Dr. James Maxwell of Ann Arbor, Mich.

On Wednesday, January 29, at 6:30 p.m., all registrants and their wives will be entertained at a cocktail party at the Americana. At 8 p.m. that evening, there will be an informal dinner for all registrants and their wives, with dancing and an outstanding floor show.

Florida Diabetes Association Annual Meeting Held

New trends in the treatment of diabetes were discussed at the Florida Diabetes Association's fifth annual meeting held at the University of Florida College of Medicine in Gainesville late in October. The three day program capsuled the most current advances with lectures and demonstrations for more than 60 Florida physicians.

Dr. William R. Jordan, Associate Professor of Clinical Medicine, Medical College of Virginia, lectured on the diagnosis and prognosis in diabetes as well as diabetes in children, the diabetic foot and the renal threshold and bladder residual as they affect the treatment of diabetes. Also serving on the faculty, Dr. Roger H. Unger, Instructor in Clinical Medicine, Southwestern Medical School of the University of Texas, spoke on the management of diabetes with oral drugs, the current status of insulin therapy as well as insulin action and metabolism, and the intravenous tolbutamide response test, which is a new diagnostic test for mild diabetes mellitus.

From The Upjohn Company's Department of Clinical Investigation, Dr. Cornelius J. O'Donovan reviewed the history of tolbutamide and discussed the mechanism of action and clinical experience with the drug. He stressed the fact that the new drug cannot be considered a substitute for insulin, but its most important contribution is in regulating mild cases of adult type diabetes for routine maintenance.

Other speakers for the session included Dr. Sanford A. Mullen of Jacksonville, who spoke on methods of determining blood and urine sugar and their clinical interpretation, and Dr. Sidney Davidson of Lake Worth, whose subject was "The Unknown Diabetic in Your Practice." Dr. Will-

iam C. Thomas Jr., Assistant Professor of Medicine and Director of the Division of Postgraduate Education of the University of Florida College of Medicine, discussed disorders accompanied by severe and often unrecognized hypoglycemia.

Moderating panel discussions were Dr. Glenn O. Summerlin of Gainesville, President of the Alachua County Medical Society, Dr. George H. Garmany of Tallahassee, incoming president of the Florida Diabetes Association, and Dr. Joseph J. Lowenthal of Jacksonville, President-Elect. Dr. Garmany succeeds Dr. Edward R. Smith of Jacksonville as president. Dr. Grover C. Collins of Palatka was named secretary-treasurer.

The meeting was held in cooperation with the Florida State Board of Health, the Florida Medical Association and the Division of Postgraduate Education of the University of Florida College of Medicine.

The New Orleans Graduate Medical Assembly

The twenty-first annual meeting of The New Orleans Graduate Medical Assembly will be held March 3, 4, 5 and 6, 1958, with headquarters at the Roosevelt Hotel.

Eighteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include 54 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposiums, medical motion pictures, round table luncheons and technical exhibits.

The Assembly has been officially approved for Category I by the Commission on Education of the American Academy of General Practice. Thirty hours of formal credit will be allowed for attendance at this meeting.

Following the meeting in New Orleans, arrangements have been made for a postclinical tour to Mexico City, Cuernavaca, Taxco and Acapulco, leaving from New Orleans on Friday, March 7, and returning on Tuesday, March 18.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12.

The list of guest speakers for the Assembly and their specialties may be found on Page 626 of this issue of The Journal.

"Jacksonville Blood Bank, Inc." A Review

The Jacksonville Blood Bank is now completing its fourteenth year of service to the community. Through war and peace an enviable record of progress has been enjoyed. In 1941, the state was asked, through the Civil Defense program, to establish five regional blood banks in Florida in order to obtain adequate supplies of blood and plasma in anticipation of military and civilian needs. The story of the bank established in Jacksonville is related in a recently published booklet entitled "Jacksonville Blood Bank, Inc."

The Jacksonville Blood Bank was launched under Civil Defense by a corporation set up for this purpose. The Board of Directors was comprised of subscribers to the charter, which was approved on March 17, 1942. Officers included Dr. Robert B. McIver, President, Dr. Lucien Y. Dyrenforth, Vice President, Mr. Warren L. Jones, Secretary, and Mr. Francis P. Fleming, Treasurer. A basic program set up for the Jacksonville Blood Bank and the other blood banks in Florida featured: (1) a governing board of laymen and professional groups, (2) nonprofit operation, (3) maintenance of financial solvency, (4) availability of an adequate supply of blood, (5) cooperation of and supervision by the medical profession with approval of the county medical society, (6) adequate provision for outlying communities, (7) a donor registry for emergencies to be established in outlying hospitals, (8) the technical procedures to be performed by trained blood bank technicians, and (9) the technical work to be under the direct supervision of a certified clinical pathologist.

The formal opening of the Jacksonville Blood Bank was held in October 1942, in a remodeled building at 2208 Otto Street, strategically located near three of Jacksonville's busy hospitals. Hundreds of blood donation were from groups of civic and religious organizations, and individual donors. The technical staff of three was assisted by volunteers from the Civil Defense Unit, and the Jacksonville Junior League, Inc. Whole blood and plasma were dispensed to individuals according to the adopted plan. Reserve plasma, processed by the Blood Bank, and a stock of dried plasma, received from the National Office of Civil Defense, were held in the event of disaster.

In 1944, termination of the emergency created by World War II and discontinance of the Civil Defense program necessitated reorganization



The modern structure, housing the Jacksonville Blood Bank, was dedicated in October 1949. The staff has increased from three persons in 1942 to 36 at the present time, and the volume of work has increased tenfold. Dr. John B. Ross is the full time Medical Director.

of the Blood Bank. A new policy, based on investigation and statistics of other blood banks, was made to meet postwar problems. Growing steadily, the Blood Bank service was expanded to meet the need of the adjacent communities. A donor reserve program, through civic and military organizations, was initiated. Mobile blood units were organized, and an agreement was made with the American Red Cross to participate in the Armed Forces Blood Procurement Program.

A charter member of the Florida Association of Blood Banks, the Jacksonville Blood Bank now had the formal approval of the National Institutes of Health. On Oct. 16, 1949, a carefully planned dream was realized — the dedication of the modern new building at 535 West Tenth Street.

After a decade of progress, a full time Medical Director, Dr. John B. Ross, was appointed. The personnel had increased from three to 36 staff members, and during the 10 year span, the Blood Bank had enjoyed a tenfold increase in volume of work. An improved community service featured: frozen plasma; blood for treatment of patients with platelet deficiency; emergency group O blood in all hospitals; arrangements to fractionate plasma into albumin, gamma globulin and fibrinogen; anti-A, anti-B, anti-Rh and Coombs' serums prepared by the Blood Bank for its own use, and mumps immune serum for patients. Other important programs included participation in the Blood Bank clearing house, similar to monetary clearing houses, for the exchange of blood and credits throughout the United States.

In 1954, the establishment of a Radioactive Isotope Department and a Tissue (Bone and Blood Vessel) Bank was a reality. This nonprofit laboratory was organized to serve the general public through private physicians.

The Watchword of the Jacksonville Blood Bank is Progress, and the goal is ever to extend the usefulness of human blood and blood products.

Dr. McIver deserves major credit for his untiring efforts since its organization to make this institution outstanding. Mrs. Edith B. Hill, editorial consultant, is likewise to be commended for her service in the preparation of the brochure.

Called Meeting of House of Delegates Florida Medical Association December 8

Dr. William C. Roberts, President of the Florida Medical Association, has called a meeting of the House of Delegates for 9 a.m., Sunday, Dec. 8, 1957, at the George Washington Hotel in Jacksonville to specifically consider Medicare. Delegates seated at the 1957 Annual Meeting are eligible to be registered and to vote.

OTHERS ARE SAYING

Is Your Pride an Asset or Liability?

Have you ever asked yourself what makes one do unreasonable, unfair, unnatural or unjust actions or reactions? It's sometimes difficult to explain or understand why the mass of protoplasm takes on a certain type of behavior. But when one speaks of behavior and the response of an adult to a situation, and the attempts to explain the factors that bring about the response, one must go back into items that constitute character, personality, heredity, environment and its influences. It's all a very complex conglomerate making a contribution to what we would call a response to a specific situation.

In this treatise I am not concerned with all the factors that control an adult's human being, but rather with us as individual physicians, and our inability to cope with these influences. One knows the decision or deed is unfair, unjust or what not and yet one is unable to throw off the powerful force that makes him commit or decide unfairly or unjustly. To be specific it has been said that some will follow a patient to death, too proud to ask for consultation. This factor in the make-up of an adult individual is commonly referred to as pride.

It intrigues me to watch this element work in the daily routine of people, one who is proud maybe satisfied, confident, secure, dignified, vain, at times arrogant, conceited, august, elated, carry high ambitions, high notions, or display egotism. The pride of some adults seems never to be satisfied. It's a potent mechanism that can make one desire, acquire, dominate, persecute, discriminate or commit common unlawful civil, social, moral or physical acts. Yet in the world of material accomplishments or acquirements it drives one to produce and achieve and possibly advance in terms of other standards. To be proud is necessary in today's competitive society, and it will continue to be a powerful characteristic of people for unforeseeable generations.

To understand one's pride and how it operates is a great achievement on the part of man, very few are capable of harnessing this great dynamo and keeping it under reasonable control. You and I are well aware of those with too much pride, and those with too little. Now in between these two extremes the mass of the population falls. As you watch the people in general too many are victims of their own pride, many are victims of the absence of pride.

In discussing the effect of pride one must necessarily discuss humility. Humility is the desirable counterpart of pride and is necessary in the proper proportion in an integrated individual. For this discussion only, an integrated individual is one who has the proper balance between pride and humility and exercises reasonable control over both. To be humble is to be shy, modest, timid, conciliatory, respectful and understanding, particularly in our profession.

You, no doubt, are wondering what all this has to do with medicine. If you recall the title of this paper—"Is your pride an asset or liability?" you will begin to see some application. When one acquires an M.D. degree he or she is rightfully a proud one, and justifiably so. Then after having worked in medicine a few years the wear and tear of the work and the changing public attitude causes your pride to give way somewhat to humility. One becomes more considerate, tolerant, understanding, conciliatory and just plain more reasonable in dealing with people and their problems. Then still more years in medicine and public service tends to dull one's pride and

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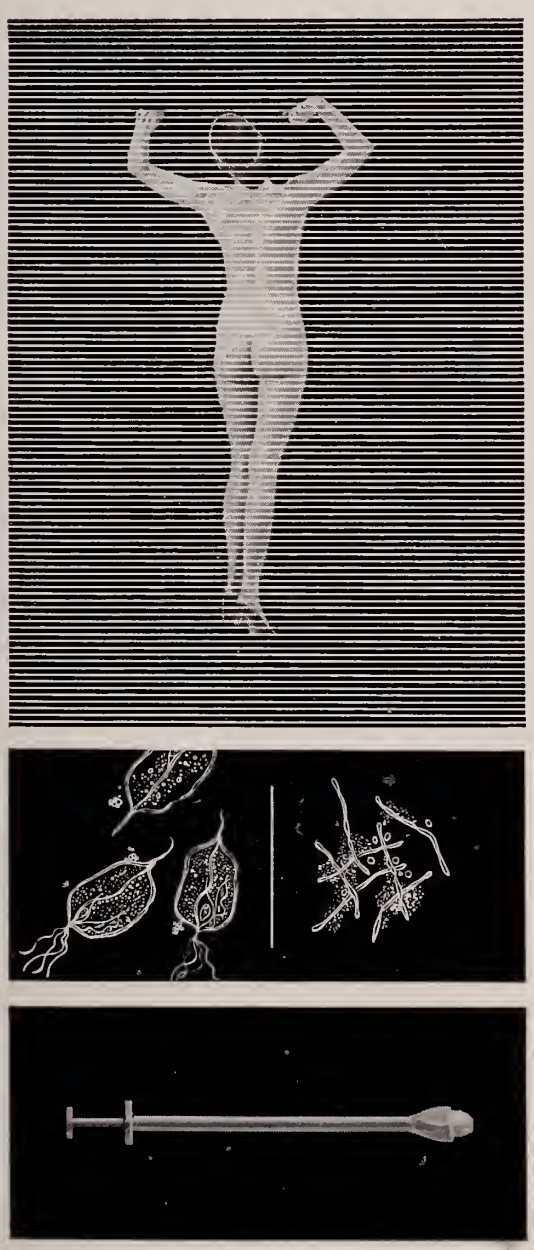
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TABLETS: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

SYRUP: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.

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*Reg. U. S. Pat. Off.

sharpen one's humility. As you watch yourself working with people and their problems you will see this change in your attitude.

Your pride then acts as an asset to cause you to do the right thing in most situations and gives you drive and determination to acquire and accomplish, and aids you to keep your moral and ethical standards high. Yet in other situations your same pride causes you to do unjust, unethical and improper acts, deeds and procedures which seem at times to be outside the realm of common sense. When you find yourself in such an unhealthy situation it is time to bring into play the element of humility to control the powerful force which has gotten out of hand. Sit down alone, think about your problem unemotionally. You see, therefore, your pride can be a liability, it can make you do something wrong.

In the practice of medicine one daily attempts to control the influence of pride and humility. To do this requires much conscious effort and control over factors in your daily life such as—economics, medical ethics, religion, politics, professional rapport, etc. Some individuals never learn to control these influences and yet some control them unconsciously, and still others handle each problem on its own merits attempting to do what is commonly referred to as the right thing with a conscious evaluation.

And so you see your pride can be an asset or a liability. You should use your pride in the practice of medicine judiciously and balance it against humility in the proper situation so that you will realize for yourself and your family the fullest self-satisfaction possible from your chosen life's work. The application of good common sense in conjunction with the basic principle of Christianity will guarantee you that your pride will be an asset and not a liability.

Walter J. Glenn
"The President's Page"
—The Record, Broward County Medical Association
September 1957

DEATHS

Deaths — Members

Adams, Texas A., Daytona Beach.....October 3, 1957
Cronkite, Alfred E., Fort Lauderdale ... October 27, 1957

Deaths — Other Doctors

MacLean, J. Arthur Jr., Miami.....September 22, 1957
Myers, Edmund, St. Petersburg September 4, 1957

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GUEST SPEAKERS

Carleton B. Chapman, M.D., Dallas, Tex.
Cardiology
Herbert Rattner, M.D., Chicago, Ill.
Dermatology
Charles A. Flood, M.D., New York, N. Y.
Gastroenterology
Robert A. Davison, M.D., Memphis, Tenn.
General Practice
Lawrence M. Randall, M.D., Rochester, Minn.
Gynecology
Bayard T. Horton, M.D., Rochester, Minn.
Internal Medicine
Perrin H. Long, M.D., Brooklyn, N. Y.
Internal Medicine
George N. Raines, Capt., MC, USN, Washington, D. C.
Neuropsychiatry
Robert H. Barter, M.D., Washington, D. C.
Obstetrics
Ralph O. Rychener, M.D., Memphis, Tenn.
Ophthalmology
C. Leslie Mitchell, M.D., Detroit, Mich.
Orthopedic Surgery
Frank D. Lathrop, M.D., Boston, Mass.
Otolaryngology
Arthur H. Wells, M.D., Duluth, Minn.
Pathology
James Marvin Baty, M.D., Boston, Mass.
Pediatrics
Harold O. Peterson, M.D., Minneapolis, Minn.
Radiology
Jere W. Lord, Jr., M.D., New York, N. Y.
Surgery
Claude E. Welch, M.D., Boston, Mass.
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Ormond S. Culp, M.D., Rochester, Minn.
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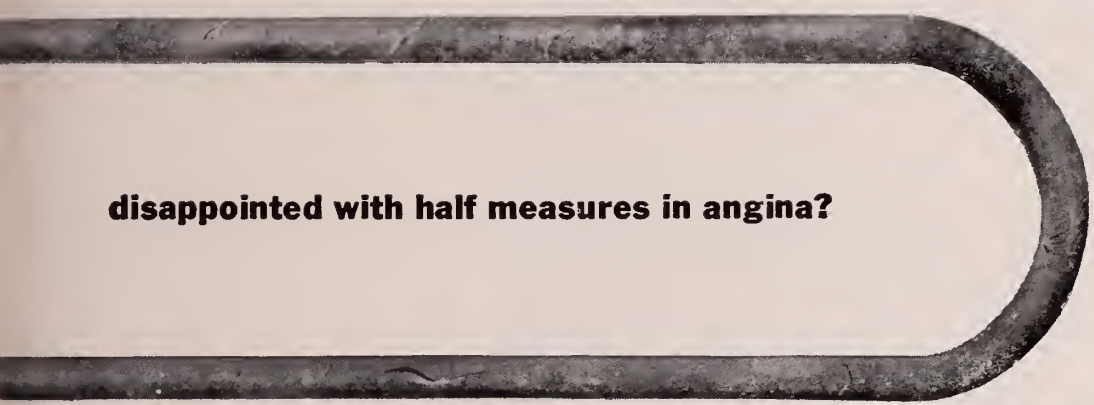
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1. Russek, H. I.: J. Am. Geriat. Soc. *4*:877 (Sept.) 1956.

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STATE NEWS ITEMS

Dr. Leon S. Eisenman of Hialeah has been elected president of the Dade County Academy of General Practice. Elected to serve with Dr. Eisenman are Dr. Jack Keefe III of Miami, vice president, and Dr. Bernard Yesner of Coral Gables, secretary and treasurer. Drs. Milton S. Goldman of Miami Beach and Vincent P. Corso of Miami have been chosen as members of the board of directors.

Dr. Ralph S. Sappenfield of Miami has been elected president of the American Society of Anesthesiologists.

Dr. Julius C. Davis of Quincy, who served as President of the Florida Medical Association in 1930, has returned to his practice at Quincy after having been away most of the past summer.

Dr. Douglas R. Murphy of Sarasota was among the group of physicians from Florida who attended the recent meeting of the American College of Surgeons held at Atlantic City.

Mediclinics third annual postgraduate refresher course will be held in Fort Lauderdale, March 2-12, 1958. The American Academy of General Practice has certified the course for 32 hours of formal postgraduate study in Category 1. The tuition fee for the course is $50 payable in advance to Mediclinics of Minnesota, 601 Medical Arts Bldg., Minneapolis 2, Minn.

A special meeting of the Florida Society of Plastic and Reconstructive Surgeons was held the latter part of September at Orlando. Attending were Drs. George W. Robertson III, president, Leo H. Wilson Jr., Clifford C. Snyder, David R. Millard Jr. and Thomas J. Zaydon of Miami ;Drs. Grover Austin and John Hamilton of St. Petersburg; Drs. Thomas Cullen and William M. Douglas of Tampa; Dr. Bernard L.N. Morgan, secretary, of Jacksonville, and Dr. Joseph E. O'Malley of Orlando.

Dr. Victor M. Arean has been appointed Associate Professor of Pathology at the University of Florida College of Medicine at Gainesville. A native of Havana, Cuba, Dr. Arean was for-

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Phenacetin	120 mg.
Salicylamide	150 mg.
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Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

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merly Associate Professor of Pathology at the University of Puerto Rico Medical School. He previously served on the faculties of the Ochsner Foundation Hospital at New Orleans and the Harvard Medical School.

Dr. William White Stead has been appointed Professor of Medicine at the University of Florida College of Medicine. Dr. Stead was formerly Associate Professor of Medicine at the University of Minnesota Medical School, a post he has held since 1949.

Dr. Melvin Simonson announces the opening of an office at 765 N.E. 125th St., North Miami, for the practice of neurology and psychiatry.

Dr. Edgar Watson of Lakeland has been elected president of the Polk County Unit of the American Cancer Society.

Dr. M. Jay Flipse of Miami served as co-chairman of a scientific session of the interim session of the American College of Chest Physicians held at Philadelphia, December 2-3.

The Marion County Medical Society, through Dr. Richard C. Cumming of Ocala, has presented the first Dr. Stewart Thompson Memorial Award to Mr. Santford Russell Wilson of Miami, a student at the University of Florida College of Medicine at Gainesville. The award was given for high scholarship.

Dr. John E. Deitrick, Dean of the Cornell University Medical College, New York, was principal speaker at the first convocation of the University of Florida Colleges of Medicine and Nursing held the later part of September. Dr. Deitrick was a member of the executive committee of the original Medical Center Study and participated in the planning of the J. Hillis Miller Health Center at Gainesville.

Dr. Gretchen V. Squires of Pensacola has recently been elected to the position of Governor of the College of American Pathologists.

The Fifth International Congress on Diseases of the Chest, sponsored by the American College of Chest Physicians, will be held Sept. 7-11, 1958 in Tokyo, Japan. It will be presented under the

patronage of the government of Japan and the Japan Science Council. Information on the meeting may be obtained from Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

The Fifty-Ninth Annual Meeting of the American Roentgen Ray Society will be held at the Shoreham Hotel in Washington, D. C., September 27-October 3, 1958.

Dr. William N. Chambers of Jacksonville has been elected president of the recently organized Duval County Psychiatric Association. Dr. Marlin C. Moore has been chosen vice president and Dr. Merton L. Ekwall secretary-treasurer. Drs. Moore and Ekwall are also from Jacksonville.

Dr. Terry Bird of Sanford was principal speaker at a recent meeting of the Sanford-Seminole Junior Chamber of Commerce held at Sanford in the Yacht Club.

Dr. Paul T. Cope of St. Petersburg represented the United States Committee as an observer at the Eleventh General Assembly of the World Medical Association held September 29 through October 5 at Istanbul, Turkey.

Dr. J. Basil Hall of Tavares addressed a recent meeting of the Lake County Tuberculosis and Health Association held at Tavares.

Dr. Leo Batell of Tampa has been chosen president of the Tampa Art Institute, an organization of 320 members which sponsors exhibitions and conducts a program of audio-visual films, lectures and demonstrations.

Dr. Redden L. Miller of Graceville was honored by that city October 20 when an entire day was set aside for tributes to him. The event was initiated by the men's groups of the First Baptist Church and the First Methodist Church. A dinner was served at noon. Invited guests were members of the Jackson-Calhoun County Medical Society.

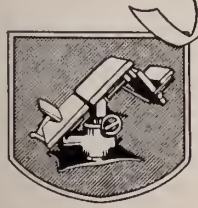
Dr. Myron L. Habegger of Rockledge, president of the Brevard County Medical Society, addressed members of the Woman's Auxiliary to the Society at its regular monthly meeting held the middle of October.

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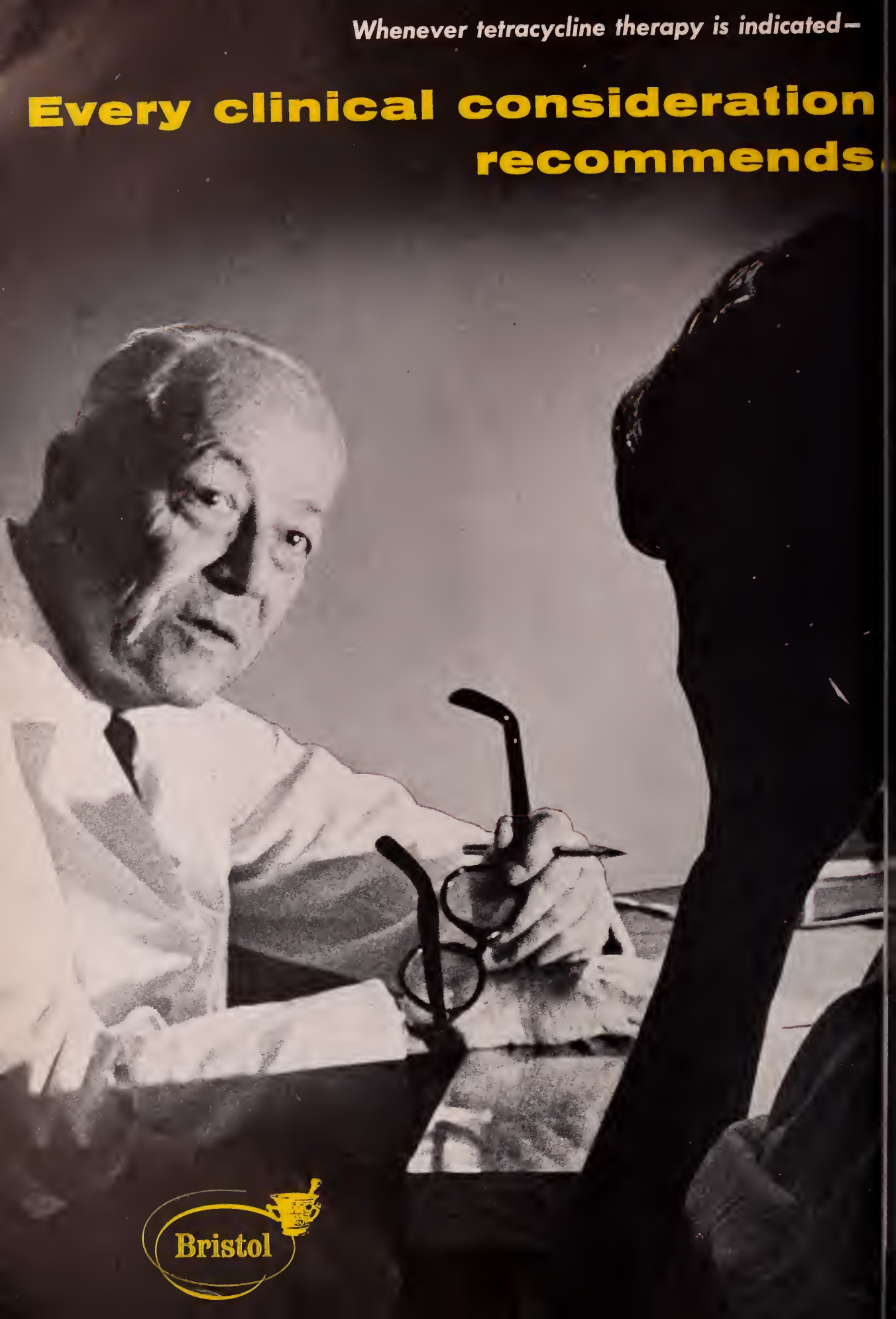
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is, H. H.; Frumess, G. M., and
schel, E. J.: Rocky Mountain M. J.
06 (Aug.) 1957.

ults of treatment with oleando-
n-tetracycline of 50 infections
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nisms and 40 infections [respira-
skin, urinary infections] due to
tive organisms are very encour-
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nemycin] was lifesaving, and in
s surgery was made unnecessary.
confirms other reports."

oin, H.: Antibiotic Med. & Clin.
apy 4:174 (March) 1957.

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Levi, W. M., and Kredel, F. E.: J. South Carolina M. A. 53:178 (May) 1957.

Of 50 patients with various infectious processes, 26 had not responded to previous antibiotic therapy. With Signemycin "Ninety-six per cent of the mixed infections were clinically controlled. . . . and in none of the cases was there any reason to discontinue the drug."

Winton, S. S., and Chesrow, E.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 55.

Signemycin in 79 patients with severe soft tissue infections: "The average response of these cases was excellent and inflammatory symptoms subsided with almost uniform rapidity....The magnitude and incidence of surgical intervention was reduced....Side reactions were minimal. . . ."

LaCaille, R. A., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67.

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Frank, L., and Stritzler, C.: Antibiotic Med. & Clin. Therapy 4:419 (July) 1957.

In the treatment of 78 patients with tropical infections, some complicated by multiple bacterial contamination or present for years, Signemycin was found to be "...an exceptionally effective agent," requiring smaller doses and less extended periods of therapy than with the tetracyclines alone, and "caused no notable toxic reactions."

Loughlin, E. H., and Mullin, W. G.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 63.

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COMPONENT SOCIETY NOTES

Brevard

The October meeting of the Brevard County Medical Society was held in conjunction with the "Crossroad Cancer Seminar" under auspices of the Florida State Board of Health. Dr. Myron L. Habegger, president of the Society, presided and introduced Dr. John Turner who in turn introduced the principal speaker, Dr. Colvin T. Klopp of George Washington University School of Medicine, Washington, D.C.

The underlying theme of Dr. Klopp's address was: "The treatment of cancer which usually has been believed to be one in which the surgeon or the radiotherapist hopes to totally exterminate a given growth with the idea that this represents a permanent cure needs a reevaluation." He brought out that cancer patients required regular periodic follow-ups, preferably by the physician who had treated the cancer apparently with success or formation of new or recurrent neoplasms.

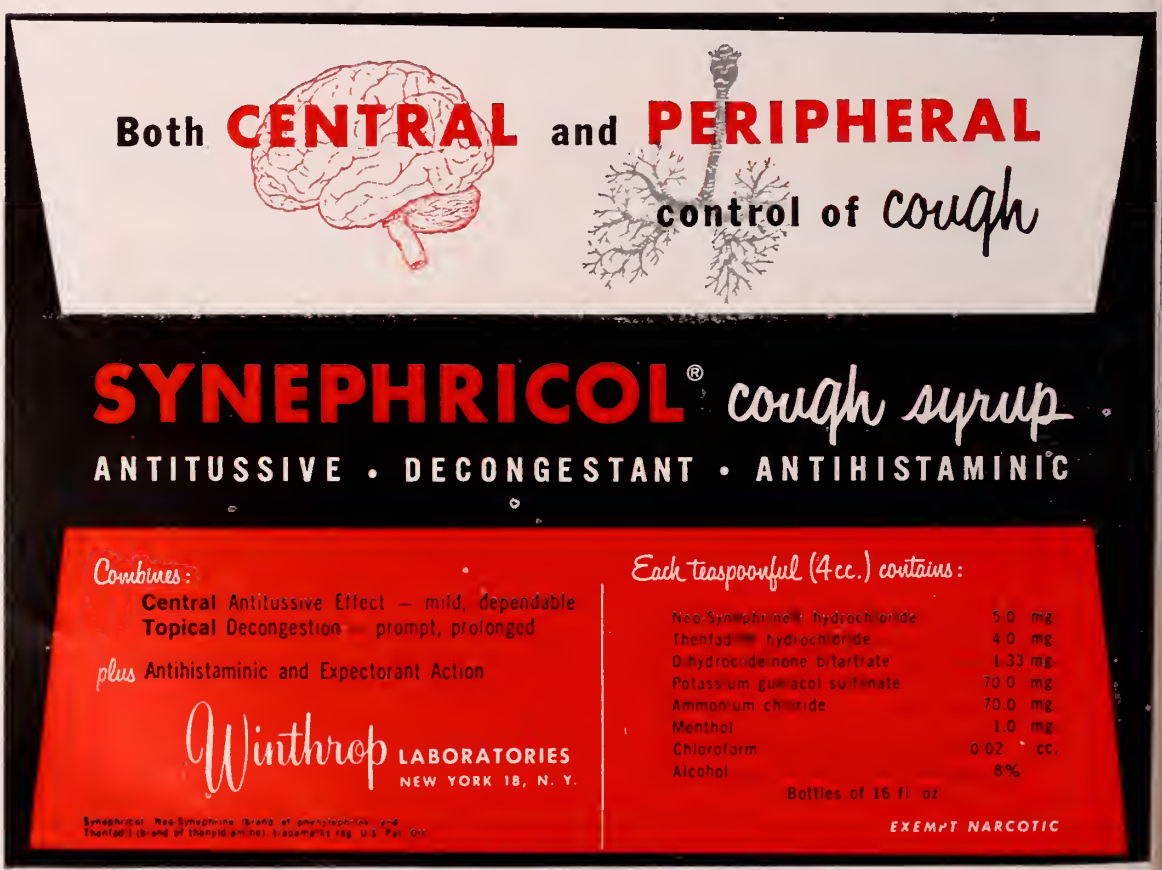
Dr. Klopp cited statistics tending to show that the cancer patient had a much greater chance of developing a similar malignancy in the same area or elsewhere or even a much different type of tumor than the non-cancer patient, and that in many respects treatment of cancer had to be considered palliative even though so-called five year cures were obtained.

Broward

Dr. Julian A. Rickles, of Miami, was principal speaker for the October meeting of the Broward County Medical Association. Meeting with the Association were members of the Broward County Dental Society.

On the program with Dr. Rickles was Dr. William Schiff, of Coral Gables. Dr. Rickles, chairman of the Dade Civil Defense Medical Council, and Dr. Schiff, chairman of the Dade Civil Defense Medical Aid Station Group, discussed the treatment of mass casualties resulting from nuclear bomb explosions.

Public forums on medical subjects are to be held jointly by the Association, the Fort Lauderdale Daily News, and the Recreation Department of the City of Fort Lauderdale. The Public Relations Committee has formulated plans for three forums, the first of which will be held the first



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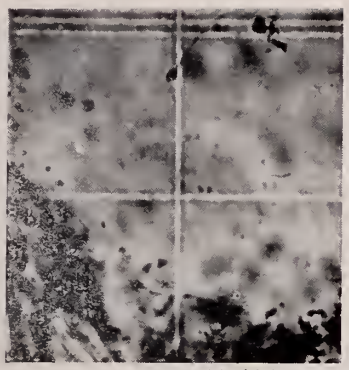
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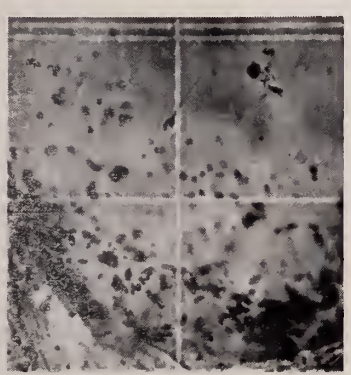
*Goldstein, L. Z.: Obst. & Gynec. *10*:133 (Aug.) 1957.

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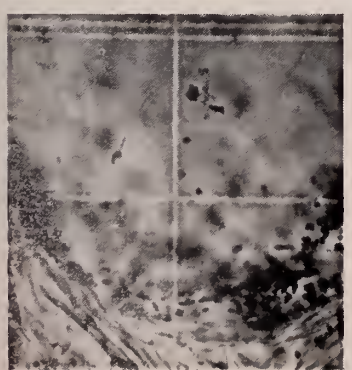
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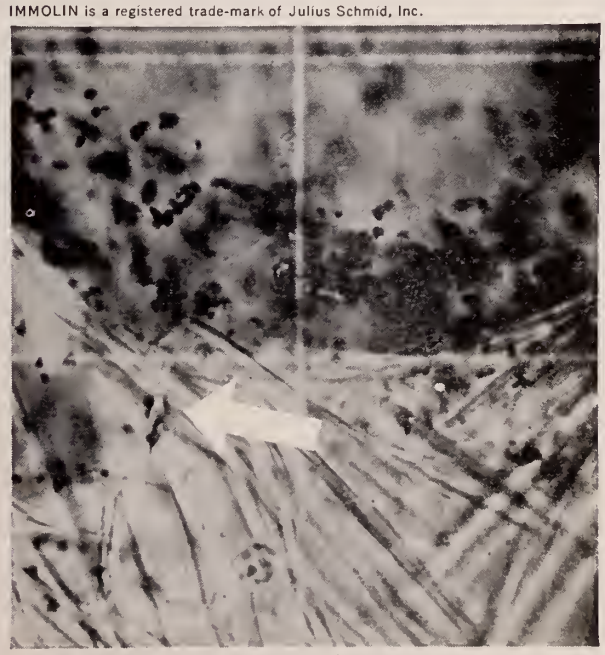
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week of December. The Fort Lauderdale Daily News conducted a poll to determine the most popular subjects and the forum topics were selected as a result of the poll.

Dr. Ernest B. Howard, Vice President of the American Medical Association, was featured speaker for the Association's November meeting. He discussed "Sociomedical Economics of Medicine." Invited guests were members of the Woman's Auxiliary to the Broward County Medical Association.

Dr. William C. Roberts, President of the Florida Medical Association, also attended the November meeting.

Dade

Dr. William C. Roberts, of Panama City, President of the Florida Medical Association was featured speaker for the November meeting of the Dade County Medical Association. He discussed some of the activities of the state association.

The executive office building of the Dade County Medical Association was dedicated on November 3 when members of the Association acted as hosts to the public. Tours through the building, brief dedicatory ceremonies and refreshments served by the Woman's Auxiliary made up the day's activities which began at 3 p.m.

Duval

Dr. Manson Meads, Associate Dean of Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C., was principal speaker for the November meeting of the Duval County Medical Society. The title of his address was "Cause of Failure of Antibiotic Therapy." Invited guests were members of neighboring county medical societies.

Hillsborough-Pinellas

The annual combined meeting of the Hillsborough County Medical Association and the Pinellas County Medical Society was held November 5. Invited guests were members of the Woman's Auxiliaries of the two societies. Principal speaker on the program was Mr. William C. Cramer, a member of the U.S. House of Representatives.

Orange

Dr. Robert E. Zellner, of Orlando, was principal speaker for the November meeting of the Orange County Medical Society. The subject for discussion was the Code of Cooperation with the Bar Association. For the October meeting, Dr. Frank J. Pyle, of Orlando, discussed "The Doctor and Investments."

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references: 1. Altschul, A. and Billow, B.: The clinical use of meprobamate. (Miltown®). New York J. Med. *57*: 2361, July 15, 1957. 2. Atwatter, J. S.: The use of anticholinergic agents in peptic ulcer therapy. J. M. A. Georgia *45*:421, Oct. 1956. 3. Borrus, J. C.: Study of effect of Miltown (2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate) on psychiatric states. J. A. M. A. *157*:1596, April 30, 1955. 4. Cayer, D.: Prolonged anticholinergic therapy of duodenal ulcer. Am. J. Digest. Dis. *1*:301, July 1956. 5. Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Experimental studies of behavioral effects of meprobamate on normal subjects. Ann. New York Acad. Sc. *67*:701, May 9, 1957. 6. Phillips, R. E.: Use of meprobamate (Miltown®) for the treatment of emotional disorders. Am. Pract. & Digest Treat. *7*:1573, Oct. 1956. 7. Selling, L. S.: A clinical study of Miltown®, a new tranquilizing agent. J. Clin. & Exper. Psychopath. *17*:7, March 1956. 8. Wolf, S. and Wolff, H. G.: Human Gastric Function, Oxford University Press, New York, 1947.

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References: (1) Gelvin, E. P.; McGavock, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. 1:155, 1956. (2) Holt, J. O. S., Jr.: Dallas M. J. 42:497, 1956. (3) Natenshon, A. L.: Am. Pract. & Digest Treat. 7:1456, 1956. (4) Council on Pharmacy and Chemistry, New and Nonofficial Remedies: J.A.M.A. 163:356 (Feb. 2) 1957.

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NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Adams, Leslie R., Jacksonville
Boothby, Richard J., Jacksonville
Braden, Frederick R., Pensacola
Brandon, James R., West Palm Beach
Doane, Joseph C., West Palm Beach
Fanizzi, William J., Fort Lauderdale
Gouchnour, Thomas H., Jacksonville
Kilgo, Frank D., Macclenny
Lees, Irving B., West Palm Beach
McCall, John B. Jr., Jacksonville
Madison, William M. Jr., Jacksonville
Martorell, Richard A., Tampa
Meriwether, Richard B., Clearwater
Nadeau, Natalie A., Fort Lauderdale
Nadeau, Oscar E., Fort Lauderdale
O'Brien, F. Kevin, Riviera Beach
Price, Robert N., Pensacola
Ptomey, William R., Century
Quehl, Thomas M. L., St. Petersburg
Ryan, Albert O. Jr., Hollywood
Spivey, Lee M., West Palm Beach
Warren, Donald E., West Palm Beach
Whitehurst, William L., Jacksonville
Young, Cabell Jr., West Palm Beach

OBITUARIES

Gordon Fuller Henry

Dr. Gordon Fuller Henry of West Palm Beach died on April 25, 1957. He was 71 years of age.

A Tennessean by birth, Dr. Henry was born in Nashville on Dec. 17, 1885. The son of Dr. George Pomeroy Henry, a prominent surgeon of that city, he represented the third generation of medical men in his family. He received his medical education at Tulane University School of Medicine, where he was awarded the degree of Doctor of Medicine in 1910.

Dr. Henry entered the general practice of medicine in Fort Myers and practiced there for 10 years. He then left to specialize in ophthalmology and otolaryngology at the University of Chicago School of Medicine. Upon his return to Florida in 1920, he located in West Palm Beach, where he practiced his specialty for 37 years. Locally, he was a member of the General

(Continued on Page 648)

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Acetylsalicylic Acid (2½ gr.)	162.0 mg.
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Hyoscyamine Sulfate	0.031 mg.
plus	
Prophenpyridamine Maleate	12.5 mg.
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(Continued from Page 646)

and Consulting Staff of the Good Samaritan Hospital.

A member of the Palm Beach County Medical Society, Dr. Henry was also a member of the Florida Medical Association, in which he held life membership. In addition, he was affiliated with the American Medical Association and his specialty societies.

Dr. Henry's wife was the former Ester Corrine Lynn of Madisonville, Ky., who preceded him in death by several years. Surviving are two children, Gordon F. Henry Jr., and Jean Henry Charlotte, both of West Palm Beach.

Charlotte Kusta Wilkins

Dr. Charlotte Kusta Wilkins of North Miami died on Nov. 4, 1956 as a result of a coronary occlusion. She was 56 years of age.

Born in Cleveland, Ohio, on Feb. 9, 1890, Dr. Wilkins was educated in her native state. She received the degree of Doctor of Medicine from Ohio State University College of Medicine in 1925 and served an internship at the Woman's Hospital in Cleveland. Later she served on the staff and was a member of the board of trustees of that hospital.

For 25 years, Dr. Wilkins was associated with the Maternal Health Association in Cleveland. She served as president of the Cleveland chapter of the American Medical Women's Association, and later headed the Miami chapter of that group.

In 1949, Dr. Wilkins was licensed to practice in Florida and located in Miami. Her practice was largely limited to office gynecology, and she devoted some time to assisting the Dade County Health Department with its school health program and in its clinic.

Dr. Wilkins was a member of the Dade County Medical Association and since 1950 had held membership in the Florida Medical Association.

Thomas Robbin Griffin

Dr. Thomas Robbin Griffin of St. Petersburg died on July 20, 1957, at his summer home in Danville, Ky., where interment took place. He was 78 years of age.

Dr. Griffin was born at Somerset, Ky., on May 5, 1880. He received his medical training at the Medical College of Ohio in Cincinnati,



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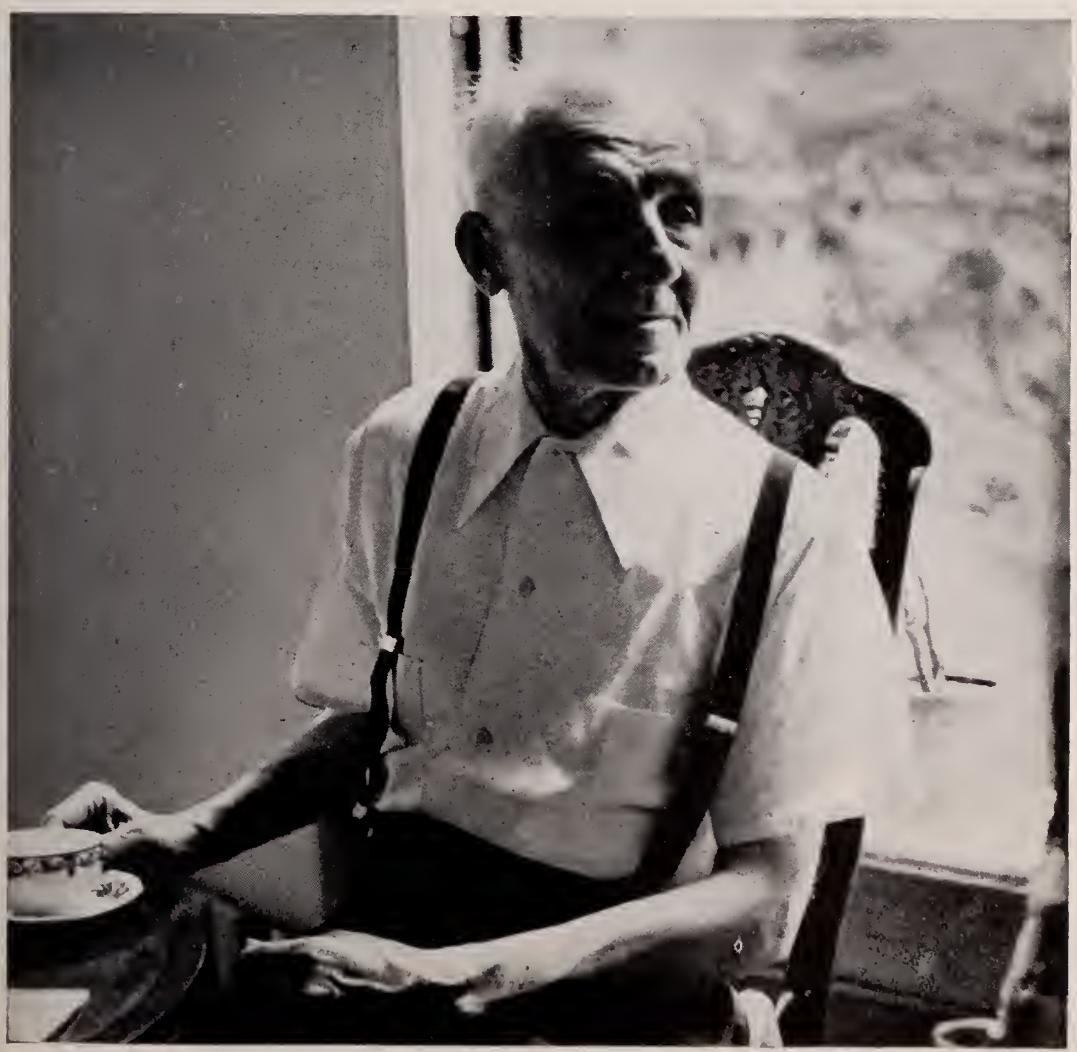
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where he was graduated in 1900. For some years prior to locating in St. Petersburg in 1920, he practiced medicine in Somerset and in Danville. During World War I, he served as an Army surgeon in the Pacific theater and was a member of the American Legion.

For 30 years prior to his retirement in 1950, Dr. Griffin was a leading surgeon and obstetrician in St. Petersburg. He was chief surgeon and physician for the Florida Power Corporation, and for three decades served as chief local surgeon for the Seaboard Airline Railroad. An original staff member of St. Anthony's Hospital in 1931, he later served as chief of staff there. He was also a staff member at Mound Park Hospital. In 1936, he was elected chief of staff at the Crippled Children's Hospital. He performed the first surgery at this Legion hospital and was among its organizers.

Dr. Griffin was a member of the Pinellas County Medical Society and since 1926 had been a member of the Florida Medical Association. He also held membership in the American Medical Association and in his specialty organizations.

Survivors include the widow, Mrs. Alvina Griffin, of St. Petersburg; one son, Bernard Griffin, of Danville; two daughters, Gertrude and Martha, and several grandchildren.

Clarence Harold Edmunds

Dr. Clarence Harold Edmunds of Miami died suddenly on Aug. 26, 1957. He was 68 years of age.

Born in Arthur, Ontario, in April 1889, Dr. Edmunds was educated in the public schools of Western Ontario and received his academic training at the University of Toronto. In 1913, he was awarded the degree of Doctor of Medicine by the University of Western Ontario Faculty of Medicine.

For nine years Dr. Edmunds practiced medicine in Ceylon, Saskatchewan, where he also owned and operated the only drug store. In 1921, he left Ceylon to attend a series of clinics at the Mayo Clinic in Rochester, Minn., and upon his return to Canada he located in Saskatoon in March 1922. His life and practice in Canada and his contributions to its growth are recorded in the Story of Saskatchewan and Its People by John Hawkes.

After additional studies in Chicago and a short stay in Orlando, Dr. Edmunds located in Miami in 1941. He rapidly built up an excellent practice and maintained it vigorously until the day of his death.

(Continued on Page 654)

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Combines Meprobamate *(400 mg.)* the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of ileitis — without fear of barbiturate loginess, hangover or habituation . . .*with* PATHILON *(25 mg.)* the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

Lederle

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LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

optimal dosages for ATARAX.
based on thousands of case histories:

25 *mg. (q.i.d.)*

for these **25** *adult indications:*

TENSION SENILE ANXIETY MENOPAUSAL SYNDROME ANXIETY PREMENSTRUAL TENSION
PHOBIA HYPOCHONDRIASIS TICS FUNCTIONAL G. I. DISORDERS PRE-OPERATIVE ANXIETY
HYSTERIA PRENATAL ANXIETY · AND ADJUNCTIVELY IN CEREBRAL ARTERIOSCLEROSIS
PEPTIC ULCER HYPERTENSION COLITIS NEUROSES DYSPNEA INSOMNIA
PRURITIS ASTHMA ALCOHOLISM DERMATITIS PARKINSONISM PSORIASIS

perhaps the safest ataraxic known

PEACE OF MIND ATARAX® (BRAND OF HYDROXYZINE) *Tablets-Syrup*

Supplied: In tiny 10 mg. (orange) and 25 mg. (green) tablets. Also now available in 100 mg. tablets. Bottles of 100. ATARAX Syrup, 10 mg. per tsp., in pint bottles. Prescription only.

10 *mg. (t.i.d.)*

for these **10** *pediatric indica*

ANXIETY TICS
TEMPER TANTRUMS

NOW: SAFE... QUICK
ATARAX® PARENTERAL SOLUTION
when Peace of Mind can't wait



In daily practice: always have it handy
- to calm the acutely disturbed or hysterical patient
- to rehabilitate the alcoholic

In hospitals: use it routinely
- to make overwrought patients manageable without loss of alertness
- to allay anxiety and control vomiting before and after surgery and childbirth

Supplied: 10 cc. multiple-dose vials. The adult dosage is 25 mg. to 50 mg. (1-2 cc.) intramuscularly, 3 to 4 times daily, at 4 hour intervals. The moderated dosage level for children under 12, when given intramuscularly, has not yet been established, and the oral dosage should be used.

Roerig Rx
NEW YORK 17, NEW YORK

New Chemotherapy

ARALEN® in RHEUMATOID ARTHRITIS

Extensive studies of rheumatoid arthritis and related collagen diseases—in this country and abroad—have shown the antimalarial Aralen phosphate to be highly effective and well tolerated in a large percentage of patients.

Clinical Results with Aralen in Rheumatoid Arthritis

Author	No. of Cases	Major Improvement	Minor Improvement	No Effect
Haydu[1]	28	22	5	1
Rinehart[2]	25	12	4	9
Freedman[3]	50	43	3	4
Bagnall[4]	108	77	12	19
Bruckner[5]	36	32	0	4
Cohen and Calkins[6]	22	17	3	2
Scherbel et al.[7]	25	9	8	8
Total	294	212 (72%)	35 (12%)	47 (16%)

- Success dependent upon persistent treatment
- Often of benefit where other agents have failed
- Remissions on therapy well maintained
- Remission of 3 to 12 months possible even if treatment is interrupted
- Tachyphylaxis not evident

GENERAL EFFECTS:

- Patient feels better
- Patient looks better
- Exercise tolerance increases
- Walking speed and hand grip improves

LABORATORY EFFECTS:

- E.S.R. may fall slowly

ANALGESICS AND STEROIDS:

- Requirements usually reduced or eliminated

JOINT EFFECTS:

- Pain and tenderness relieved
- Mobility increases
- Swellings diminish or disappear
- Muscle strength improves
- Rheumatic nodules may disappear
- Even severe or advanced deformity may improve
- *Active* inflammatory process usually subsides
- Joint effusion may diminish

DOSAGE:

Aralen is cumulative in action and requires four to twelve weeks of administration before therapeutic effects become apparent.

Latest information indicates that an initial dose of 250 mg. of Aralen phosphate is preferable to the higher doses sometimes recommended. However, if side effects appear, withdraw Aralen for several days until they subside. Reinstate treatment with 125 mg. daily and, if well tolerated, increase to 250 mg. The usual maintenance dose is 250 mg. daily.

New Chemotherapy

INDICATIONS:

- Rheumatoid arthritis, acute or chronic —with or without adjunctive therapy.
- Spondylitis
- Arthritis associated with lupus erythematosus or psoriasis

THEORY OF ACTION:

Aralen appears to suppress or induce remission of rheumatoid inflammatory processes by inhibiting adenosinetriphosphatase.

HOW SUPPLIED:

Aralen phosphate: 250 mg. tablets in bottles of 100 and 1000.
125 mg. tablets in bottles of 100.

Tolerance:

Aralen is usually well tolerated. Toxic effects are usually mild and to date have been transitory in nature, disappearing completely either on continuance or cessation of therapy or on reduction in dosage.

Gastrointestinal disturbances (e.g. nausea, rarely vomiting, diarrhea, abdominal cramps, anorexia) are frequent manifestations of intolerance. Temporary blurring of vision (due to interference with accommodation) is also relatively frequent.

Pleomorphic skin eruptions (e.g. lichenoid, maculopapular, purpuric), although generally mild, may preclude the use of an optimum dosage schedule. If a skin reaction persists on a reduced dosage schedule, or recurs after reinstitution of treatment with gradually increasing doses, discontinue Aralen till the lesion again disappears and consider resuming treatment with Plaquenil® brand of hydroxychloroquine).

Less frequently transitory vertigo, headache, lassitude, or neurological disturbances, such as nervousness, irritability, emotional change, and nightmares have been reported. Instances of unexplained slight gradual weight loss as the patient's general health and arthritic condition improved have been mentioned. Occasional instances of bleaching (depigmentation) of the hair have been described.

Although an occasional instance of leukopenia, with normal differential count, has been reported (WBC about 3000), it has not proved troublesome because it has always been reversible on discontinuance, or diminution of the dose. Even spontaneous reversal may occur while full dosage is maintained.

Caution:

Aralen is known to concentrate in the liver and, although hepatic damage has never been reported, the drug should be used with caution in the presence of liver disease. In the presence of severe gastrointestinal, neurological, or blood disorders, the drug should be used with caution or not at all. If such disorders occur during the course of therapy, the drug should be discontinued. Concomitant use of gold or phenylbutazone with Aralen should be avoided because of the tendency of these agents to produce drug dermatitis.

Clinical Comments:

Of fifty patients receiving Aralen therapy, "43 have become really well; that is, they have no stiffness, and any pain that occurs can reasonably be attributed to use of joints affected by secondary degenerative changes. They have no evidence of joint inflammation, but may have a raised erythrocyte sedimentation rate. They have little or no need for analgesics." *Freedman*[3]

"One hundred and twenty-five private patients have been carefully followed clinically and haematologically while receiving well over 200 patient-years of chloroquine [Aralen] therapy. The results are considered good in 70%, one-half of these cases being in remission. Improved work performance, sedimentation rate, and hemoglobin levels paralleled the major objective gain in this 70%. 90% of them remained on chloroquine [Aralen] therapy, half for more than two years. Classical peripheral rheumatoid arthritis, spondylitis, arthritis of juvenile onset, and rheumatoid disease with psoriasis, all appeared to respond about equally well.

"It is suggested that chloroquine comes closer to the ideal for long-term, safe, control of rheumatoid disease than any other agent now available." *Bagnall*[4]

"Out of the 36 rheumatoid arthritis cases we treated . . . favorable results were obtained in 32 cases. *Bruckner et al.*[5]

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Winthrop LABORATORIES
NEW YORK 18, N.Y.

(Continued from Page 650)

In Canada, Dr. Edmunds was a member of the Canadian Medical Association, the Saskatchewan Medical Society and the Saskatoon Academy of Medicine. Since coming to Florida, he had been a member of the Dade County Medical Association and the Florida Medical Association. He also held membership in the American Medical Association.

Surviving are the widow, Mrs. Bernadette Edmunds, of Miami; a daughter, Mrs. Lynette Bernbaum, of Chicago; and a granddaughter.

Lucien Evans Myers

Dr. Lucien Evans Myers of Winter Park died on July 11, 1957, at the Veterans Hospital in Gulfport, Miss., after an illness of several years. He was 54 years of age. Interment took place in the national cemetery at Gulfport.

Dr. Myers was born in Mobile, Ala., on March 7, 1903. He was a graduate pharmacist and taught chemistry at Clemson College and biochemistry at the University of Tennessee College of Medicine before entering medical school. He was awarded the degree of Doctor of Medicine by the Tulane University School of Medicine in 1932. He interned at Bassett Hospital in Cooperstown, N. Y., and later engaged in postgraduate work in gastroenterology at the Lahey Clinic.

For some years Dr. Myers practiced in Cherry Valley, N. Y. In 1942, he came to Florida and located in Winter Park. He practiced his specialty of internal medicine there until he entered military service in World War II. He served as a lieutenant commander in the Navy and had combat service in the Pacific theater. After he was released from military duty, he returned to Florida, practicing for a time in Orlando before returning to Winter Park.

Dr. Myers was a member of the Orange County Medical Society and of the Florida Medical Association. He also held membership in the American Medical Association.

Survivors include the widow, Mrs. Helen Colley Myers, of Winter Park; his mother, Mrs. Mary Elizabeth Myers, of New Orleans, La.; three brothers, Horace Myers, of Memphis, Tenn., Kenneth Myers, of Kansas City, Mo., and E. B. Byers, of St. Louis, Mo.; and three sisters, Mrs. James Gillis, of New Orleans, Mrs. Russell Woods, of Timmonsville, S. C., and Mrs. Earl Cesalu, of Anita, La.

when anxiety and tension "erupts" in the G. I. tract...

in spastic and irritable colon



PATHIBAMATE*

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Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer... helps control the "emotional overlay" of spastic and irritable colon—without fear of barbiturate loginess, hangover or habituation... *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

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In Ireland, too, Pentothal is used almost constantly

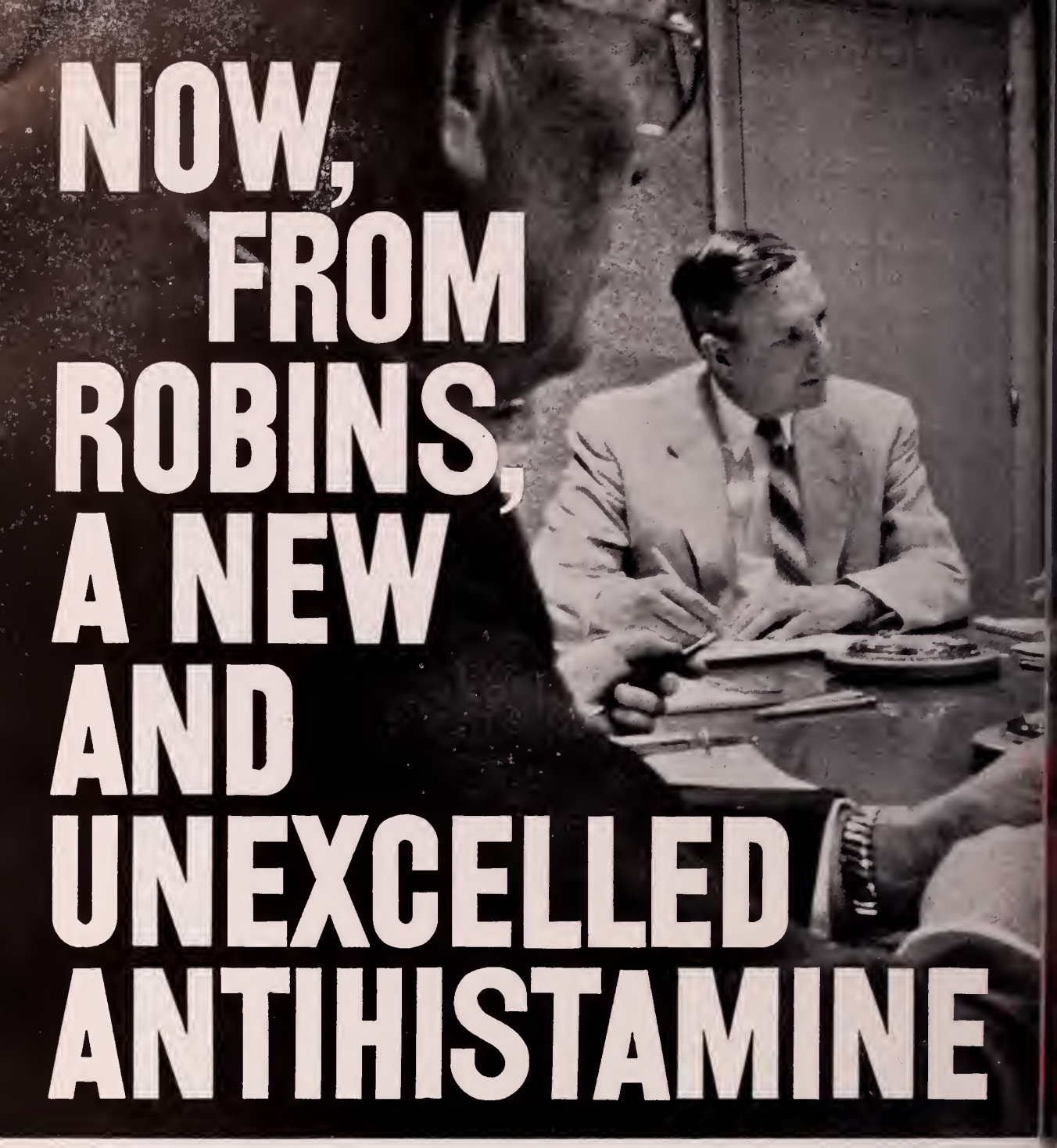


**Unmistakably
the world's most widely studied
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With PENTOTHAL Sodium, there is no prolonged induction period. Recovery is smooth, rapid, because there is little drug to be detoxified. And PENTOTHAL is economical because the *total* dosage to achieve the desired levels of anesthesia is small. More than 2800 published reports, over 23 years of use . . . make it an "agent of choice" wherever modern intravenous anesthesia is practiced. Abbott

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(Thiopental Sodium for Injection, Abbott)



NOW, FROM ROBINS, A NEW AND UNEXCELLED ANTIHISTAMINE

why Dimetane is the best reason yet for you to re-exami
the antihistamine you're now using »*Milligram for milligr*

DIMETANE potency is unexcelled. DIMETANE has a therapeutic index unrivaled by other antihistamine—a relative safety unexceeded by any other antihistamine. DIMETANE, even in very low dosage, has been effective when other antihistamines have failed. Drowsiness, other side effects have been at the very minimum.

Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Drow
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1	-	Slight Drow
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness Dizzy (1)

» unexcelled antihistaminic action

From the preliminary **Dimetane Extentabs** studies of three investigators. Further clinical investigations will be reported as



it's easy to remember **Di me tane**

Dimetane®

EXTENTABS® TABLETS ELIXIR

DIMETANE IS PARABROMDYLAMINE MALEATE — EXTENTABS 12 MG., TABLETS 4 MG., ELIXIR 2 MG. PER 5 CC.

lanket of allergic protection, covering 10-12 ırs—with just one Dīmetane Extentab » *DIMETANE entabs protect patient for 10-12 hours on one tablet.*



Periods of stress can be easily handled with supplementary DIMETANE Tablets or Elixir to obtain maximum coverage.

Dosage:

Adults—One or two 4-mg. tabs. or two to four teaspoonfuls Elixir, three or four times daily. One Extentab q.8-12 h. or twice daily.

Children over 6—One tab. or two teaspoonfuls Elixir t.i.d. or q.i.d., or one Extentab q.12h.

Children 3-6—½ tab. or one teaspoonful Elixir t.i.d.

A. H. ROBINS CO., INC.

Robins

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NICOZOL
for senile psychoses

From CONFUSION

NICOZOL relieves mental confusion and deterioration, mild memory defects and abnormal behavior patterns in the aged.

NICOZOL therapy will enable your senile patients to live fuller, more useful lives. Rehabilitation from public and private institutions may be accomplished for your mildly confused patients by treatment with the Nicozol formula. [1] [2]

NICOZOL is supplied in capsule and elixir forms. Each capsule or ½ teaspoonful contains:

Pentylenetetrazol . . 100 mg.
Nicotinic Acid 50 mg.

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to a NORMAL BEHAVIOR PATTERN

WRITE for **FREE NICOZOL**

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for professional samples of
NICOZOL capsules and literature on
NICOZOL for senile psychoses.



If
Monilial
overgrowth
is a factor

ACHROSTATIN *V

Tetracycline (phosphate-buffered) and Nystatin

Combines ACHROMYCIN V with NYSTATIN

ACHROSTATIN V combines ACHROMYCIN† V... the new rapid-acting oral form of ACHROMYCIN† Tetracycline... noted for its outstanding effectiveness against more than 50 different infections... and NYSTATIN... the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients who are prone to monilial overgrowth during a protracted course of antibiotic treatment.

supplied:
ACHROSTATIN V CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin.

dosage:
Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

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both-
orally for
dependable prophyl
sublingually for
fast relief

NEW

ISUPREL®

FOR CHEERFUL INSTEAD OF FEARFUL PATIEN



TRANOL® TABLETS

HMATIC—
eerful instead of fearful

suprel-Franol tablets bring
he-clock relief *plus* emergency
ainst sudden attack. Anxiety
hen patients know they'll get
60 seconds — relief that con-
or four hours or more.

HCl (10 mg. for adults, 5 mg.
dren), the most potent broncho-
known, makes up the outer
In a sudden attack, the patient
tablet under his tongue. Relief
60 seconds. A unique feature
lavor-timer." As the Isuprel is
d a lemon flavor appears. When
pears—about five minutes later
atient swallows the tablet.

xcelled combination for pro-
ronchodilatation makes up the
Franol core: benzylephedrine
2 mg.), Luminal® (8 mg.) and
lline (130 mg.). Swallowed, the
orks for four hours or more.

Franol tablets are "... effec-
controlling over 80% of
with mild to moderate
of asthma."[1]

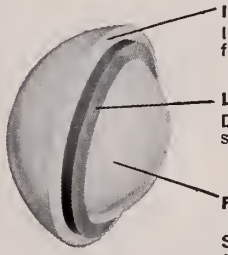
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1956.

Rx

Isuprel-Franol Tabs
No. 100
Sig 1 tablet t.i.d.
If attack occurs,
place 1 tablet under
tongue, swallow after
five minutes

ISUPREL-FRANOL
tablets (Isuprel HCl 10 mg.) for adults;
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Mild tablets (Isuprel HCl 5 mg.) for children:
One tablet every three or four hours taken *orally* for continuous control of bronchospasm in chronic asthma. One tablet taken *sublingually* for sudden attack. "Flavor-timer" signals when patient should swallow.
Bottles of 100 tablets.

"Flavor-timer" signals patients when to swallow tablets



ISUPREL
Immediate effect sublingually—for emergency use

LEMON "FLAVOR-TIMER"
Disappearance of flavor is the signal to swallow

FRANOL { Theophylline / Luminal / Benzylephedrine
Sustained action—reduces frequency and intensity of attacks

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RAND OF ISOPROTERENOL), FRANOL AND LUMINAL (BRAND OF PHENOBARBITAL). TRADEMARKS REG. U. S. PAT. OFF.

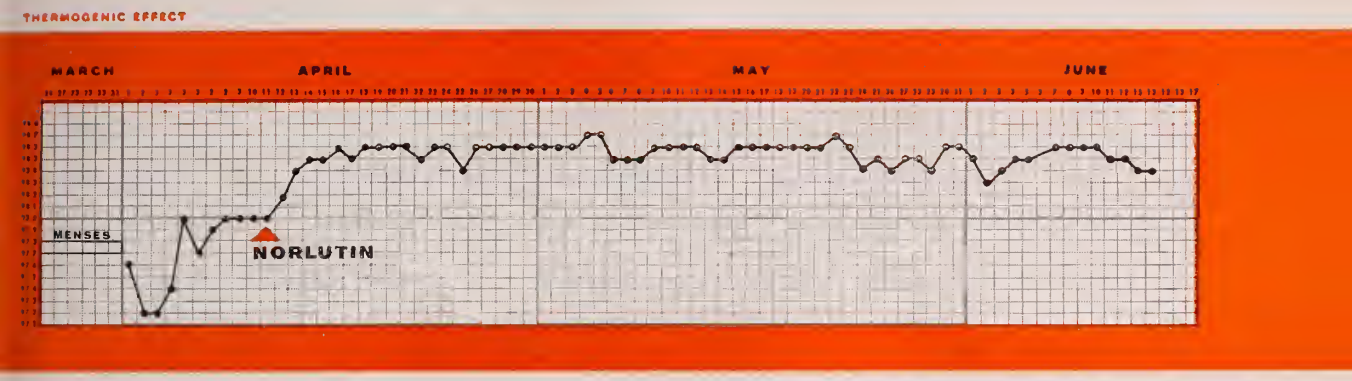
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Make your pause at work
truly refreshing. Have a frosty bottle
of pure, delicious Coca-Cola
...and be yourself again.



***oral* progestational agent**
with
unexcelled potency
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With NORLUTIN you can now prescribe truly effeetive *oral* progestational therapy. Small oral doses of this new and distinetive progestogen produce the biologie effeets of injeeted progesterone.



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NORLUTIN T.M.

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major advance in female hormone therapy for certain disorders of menstruation and pregnancy

INDICATIONS FOR NORLUTIN: conditions involving defieiency of progestogen, such as primary and secondary amenorrhea, menstrual irregularity, functional uterine bleeding, endocrine infertility, habitual abortion, threatened abortion, premenstrual tension, and dysmenorrhea.

PACKAGING: 5-mg. scored tablets (C. T. No. 882), bottles of 30.

*Greenblatt, R. B.: *J. Clin. Endocrinol.* 16:869, 1956.

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AZOTREX is the only urinary anti-infective agent combining:

(1) the broad-spectrum antibiotic efficiency of TETREX—the original tetracycline phosphate complex which provides faster and higher blood levels;

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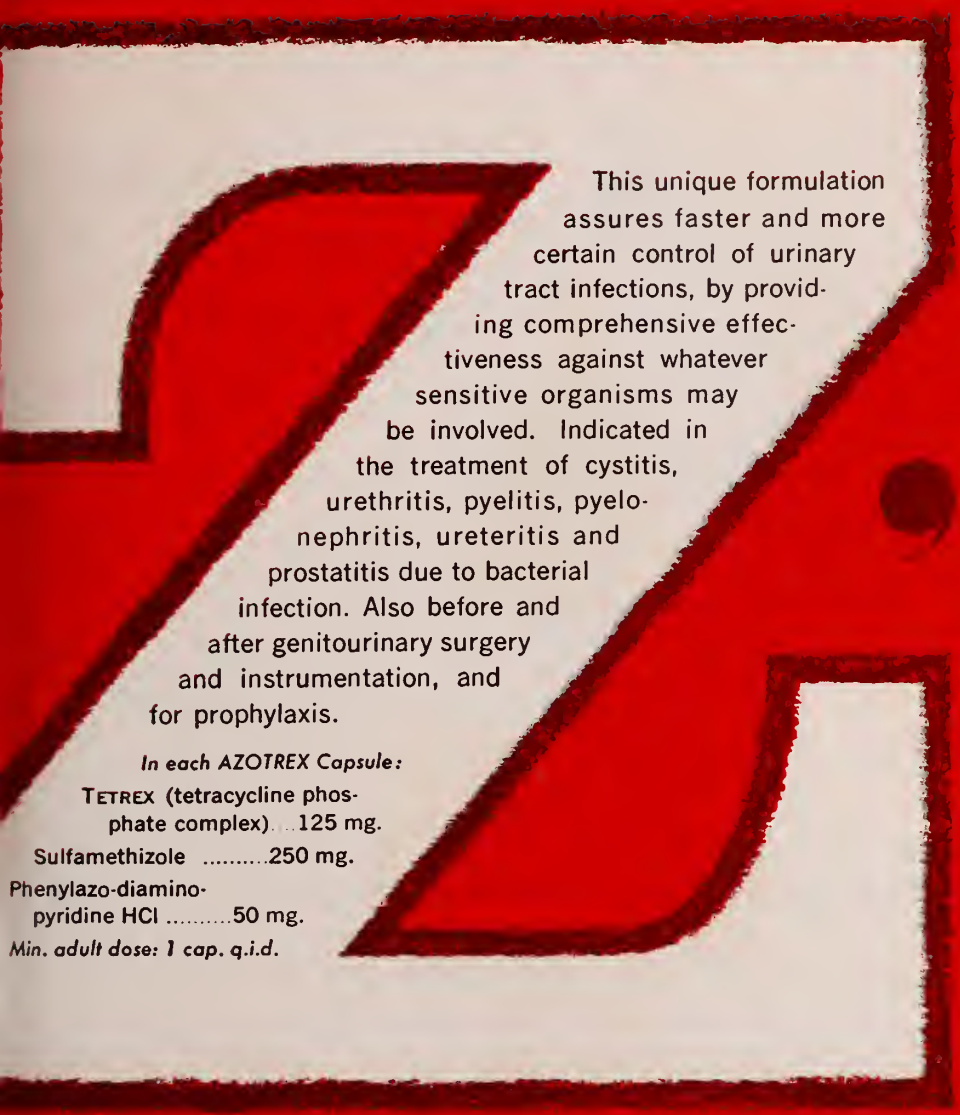
(3) the pain-relieving action of phenylazo-diamino-pyridine HCl—long recognized as a urinary analgesic.

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This unique formulation assures faster and more certain control of urinary tract infections, by providing comprehensive effectiveness against whatever sensitive organisms may be involved. Indicated in the treatment of cystitis, urethritis, pyelitis, pyelonephritis, ureteritis and prostatitis due to bacterial infection. Also before and after genitourinary surgery and instrumentation, and for prophylaxis.

In each AZOTREX Capsule:

TETREX (tetracycline phosphate complex) ... 125 mg.
Sulfamethizole 250 mg.
Phenylazo-diamino-pyridine HCl 50 mg.

Min. adult dose: 1 cap. q.i.d.

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CAPSULES



Rx *why wine in geriatrics and convalescence?*

Convalescents, regardless of their years, share many of the tonic and recuperative needs of the aged, and wine is probably more widely recommended in the care of these patient groups than in any other.

Many generations of physicians have warmly advocated not only dry table wines but also sweet dessert wines of many varieties for their nutritional value in elderly and convalescent patients.

Now modern research supplies the raison d'être by clearly showing that wine not only supplies quick fuel but also serves to stimulate the desire for food where appetite is poor.

WINE AIDS DIGESTION—Wine has been found to increase salivary flow,[1] stimulate gastric secretion[2] and facilitate the gastrocolic reflex.[3]

WINE FOR GENTLE, SAFE SEDATION—Described as the safest of all sedatives, wine can often dispel the anxieties, fears and emotional pressures of old age and prolonged illness. The relaxation of gastric tension produced by moderate amounts of wine may be a significant factor in the prevention of dyspepsia. The systemic sedative[4] and vasodilative[5] actions of wine can be of great aid in cardiovascular disease.

For a few cents a day your patients can have wines produced from the world's finest grape varieties grown in an ideal climate and handled with consummate skill.

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assure her

a more serene, a happier pregnancy
. . . without nausea

give her **'MAREDOX'®** brand

Cyclizine Hydrochloride and Pyridoxine Hydrochloride

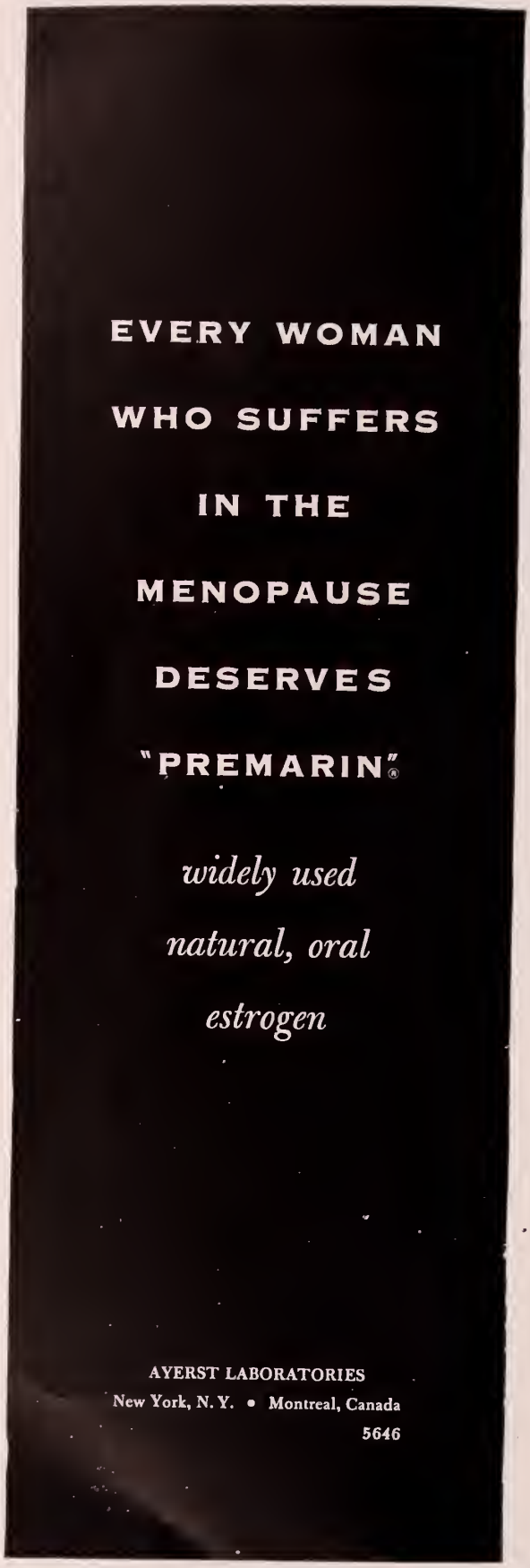
because 'Maredox' gives the expectant mother new-found relief from morning sickness.

relieves nausea and vomiting
and
counteracts pyridoxine deficiency
in pregnancy

One tablet a day, taken either on rising or at night, is all that most women require.

Each tablet of 'Maredox' contains:
'Marezine'® brand Cyclizine Hydrochloride. 50 mg.
Pyridoxine Hydrochloride 50 mg.

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Report of Fall Conference Of Presidents and Presidents-Elect

The Fall Conference in Chicago for Presidents and Presidents-Elect had four Florida members representing our fair state. Mrs. Richard F. Stover, Miami, Third Vice President of the Woman's Auxiliary to the American Medical Association and Regional Membership Chairman for the Southern States, had all us at work helping her be hospitable to other Southern Presidents and Presidents-Elect. All were so genuinely friendly and nice, it was a pleasure to be associated with them.

Mrs. Samuel S. Lombardo of Jacksonville, Southern Regional Chairman of the Safety Committee of the Woman's Auxiliary to the American Medical Association, conferred at length with the national chairman, Mrs. John Wagner of Pennsylvania, Peggy's home state, and other members of this new and important committee.

Safety, by special request of the A.M.A., is to be one of our "priority projects" this year. So be prepared when you shop for that new car to having your wife insist on safety devices such as shock absorbing padding on the dash and visors, recessed knobs and seat belts or harnesses. It seems accident prevention is such a slow process that the immediate requirement is to protect yourself, your wife and children. When the three daughters of your next door neighbor are killed in an automobile accident, leaving six motherless children, and the daughter of one of your oldest friends is killed only fifty miles from home as she began her honeymoon, you cannot help but stop and consider what you can do to prevent such tragedies. One thing everybody can do is demand safety devices as standard equipment in their new cars thereby making the automobile manufacturers conscious of their shortcomings in this respect.

Today's Health is to be another Auxiliary "priority project" for the year and the appointment of Mr. James Liston, formerly with Better Homes and Gardens, as full time editor was an-

nounced. The magazine will be changed considerably this coming year and will provide better reading for the anxious patient waiting in your reception room. We have been asked this year by the A.M.A. to emphasize "Reception Room Readership," one reason being that advertising revenue is based on circulation and a copy in your reception room will reach at least fifty times the number of persons as the copy in your home. It is estimated that 331 million persons will visit doctors' offices this coming year and if each one learned only one medical fact from the copy of Today's Health there, think of all the needless explaining that would be saved. Some doctors give a subscription to every new mother when her bill is fully paid, and they estimate from five to ten phone calls are saved by each one.

Also persons in a doctor's reception room are vitally interested in health and will be receptive to authentic and factual health information. Our "Operation Christmas" is under way, so alert your secretary to be ready when she is called by an Auxiliary member for your new or renewal subscription. Escambia County Auxiliary won this national contest last year for their membership group and we would like to do as well or better this year. You can do your Christmas shopping in the easy way by giving a subscription to Today's Health—to your dentist, who discounts your bills if he charges you at all; to your barber, for being so kind to those thinning locks, and to your office nurse, so she will leave your copy in the reception room. Better yet, let your wife get all the subscriptions and save yourself the worry.

Mrs. Perry D. Melvin

Eighty-Fourth Annual Meeting
Florida Medical Association
Hotel Americana, Miami Beach
May 10-14, 1958



Allen's Invalid Home

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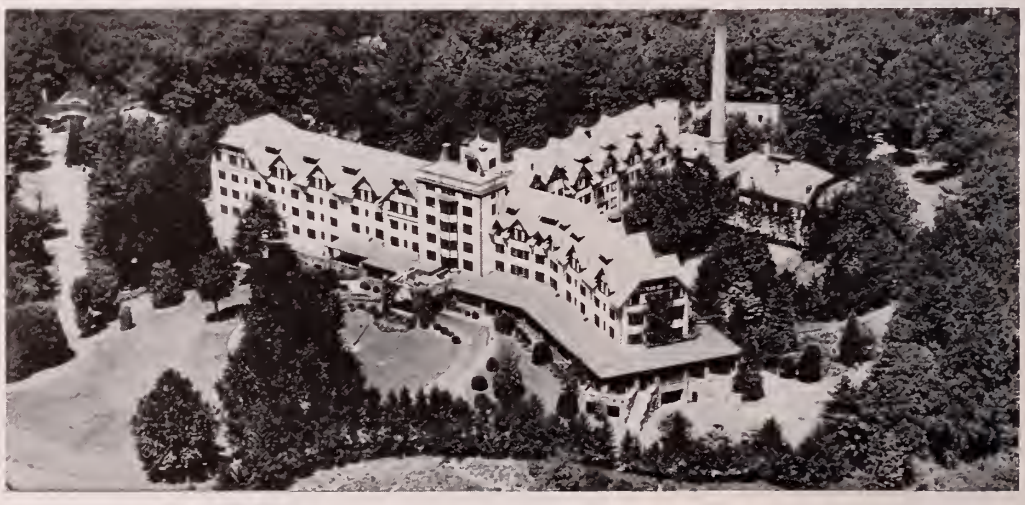
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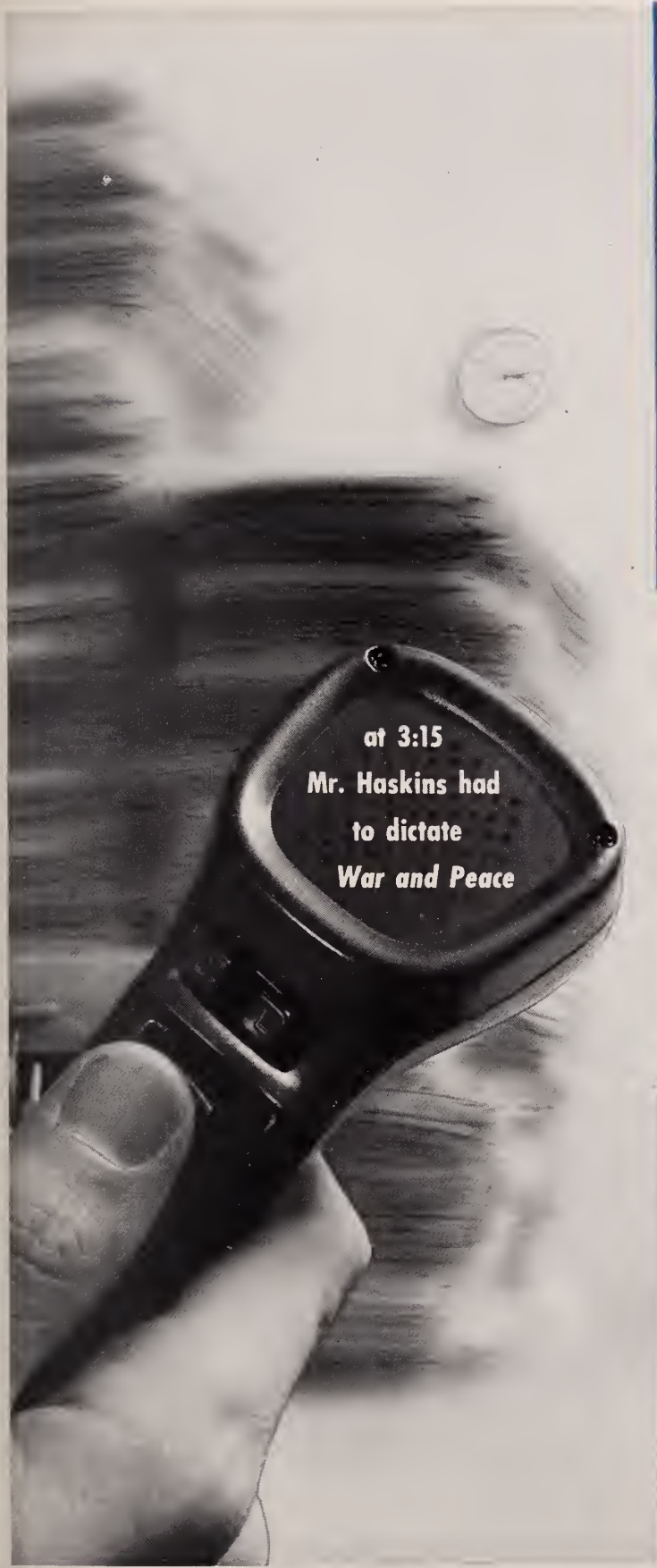
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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Glenn O. Summerlin, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	64
***Bradford, Gilchrist, Union**				
Bay	John J. Benton, Panama City	Lloyd B. Harrison Jr., Panama City	1st Tues.	29
Brevard	Myron L. Habegger, Rockledge	Louis C. Jensen Jr., Rockledge	2nd Tues.	52
Broward	Walter J. Glenn Jr., Fort Lauderdale	Garland M. Johnson, Fort Lauderdale	4th Tues.	177
Collier	James A. Craig, Naples	Ethel H. Trygstad, Naples	3rd Wed.	9
Columbia	Thomas H. Bates, Lake City	Laurie J. Arnold Jr., Lake City	1st Mon.	11
***Baker**				
Dade	Walter W. Sackett Jr., Miami	Vincent P. Corso, Miami	1st Tues.	820
DeSoto-Hardee-Highlands-Glades	Godfrey L. Beaumont, Sebring	Theodore W. Weeks Jr., Sebring	1st Tues.	28
Duval	Leo M. Wachtel, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	339
***Clay**				
Escambia	Paul F. Baranco, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	114
Franklin-Gulf	Photis J. Nichols, Apalachicola	William F. Wager, Port St. Joe	Last Wed.	6
Hillsborough	Madison R. Pope, Plant City	James A. Winslow Jr., Tampa	1st Tues.	226
Indian River	Walter W. McCorkle, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	10
Jackson-Calhoun	William W. Richardson, Graceville	Francis M. Watson, Marianna	Quarterly	15
Lake	Fred A. Vincenti, Mount Dora	J. Basil Hall, Tavares	1st Wed.	31
***Sumter**				
Lee-Charlotte-Hendry	James L. Bradley, Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	39
Leon-Gadsden-Liberty-Wakulla-Jefferson	George S. Palmer, Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	76
Madison	Julian M. DuRant, Madison	A. Franklin Harrison, Madison		8
Manatee	Joseph A. Gibson, Bradenton	Warren G. Darty, Palmetto	2nd Tues.	31
Marion	John D. Lindner, Ocala	Robert L. Gibson, Ocala	3rd Tues.	36
***Levy**				
Monroe	Robert W. Reid, Key West	Joseph J. Scarlet, Key West	1st Thurs.	13
Nassau	Benj. F. Dickens, Fernandina Beach	David D. Bennett Jr., Callahan	1st Thurs.	9
Orange	Frank J. Pyle, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	219
***Osceola**				
Palm Beach	Edward W. Wood, Lake Worth	Robert Y. Wheelihan, Riviera Beach	4th Mon.	166
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	19
Pinellas	Whitman H. McConnell, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	262
Polk	John P. Tomlinson Jr., Lake Wales	Charles Larsen Jr., Lakeland	2nd Wed.	115
Putnam	Alfred P. Peretti, Palatka	Norman B. Edgerton, Palatka	2nd Tues.	11
St. Johns	Milton Segal, St. Augustine	William J. Gibson, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	John M. Gunsolus, Stuart	Adrian M. Sample, Fort Pierce	3rd Thurs.	28
Sarasota	Samuel E. Kaplan, Venice	James E. Kicklighter, Sarasota	2nd Tues.	69
Seminole	Gordon D. Stanley, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee-Hamilton-Lafayette	Hiram B. Curry, Jasper	William P. Blackmon, Jasper	1st. Sat.	11
Taylor	Charles R. Wiley, Perry	Ralph J. Greene, Perry	Last Fri.	6
***Dixie**				
Volusia	Arthur Schwartz, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	89
***Flagler**				
Walton-Okaloosa-Santa Rosa	Ralph B. Spires, DeFuniak Springs	Howard A. Parker, Valparaiso	3rd Tues.	28
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay		4
				Total 3,211

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REFERENCES:

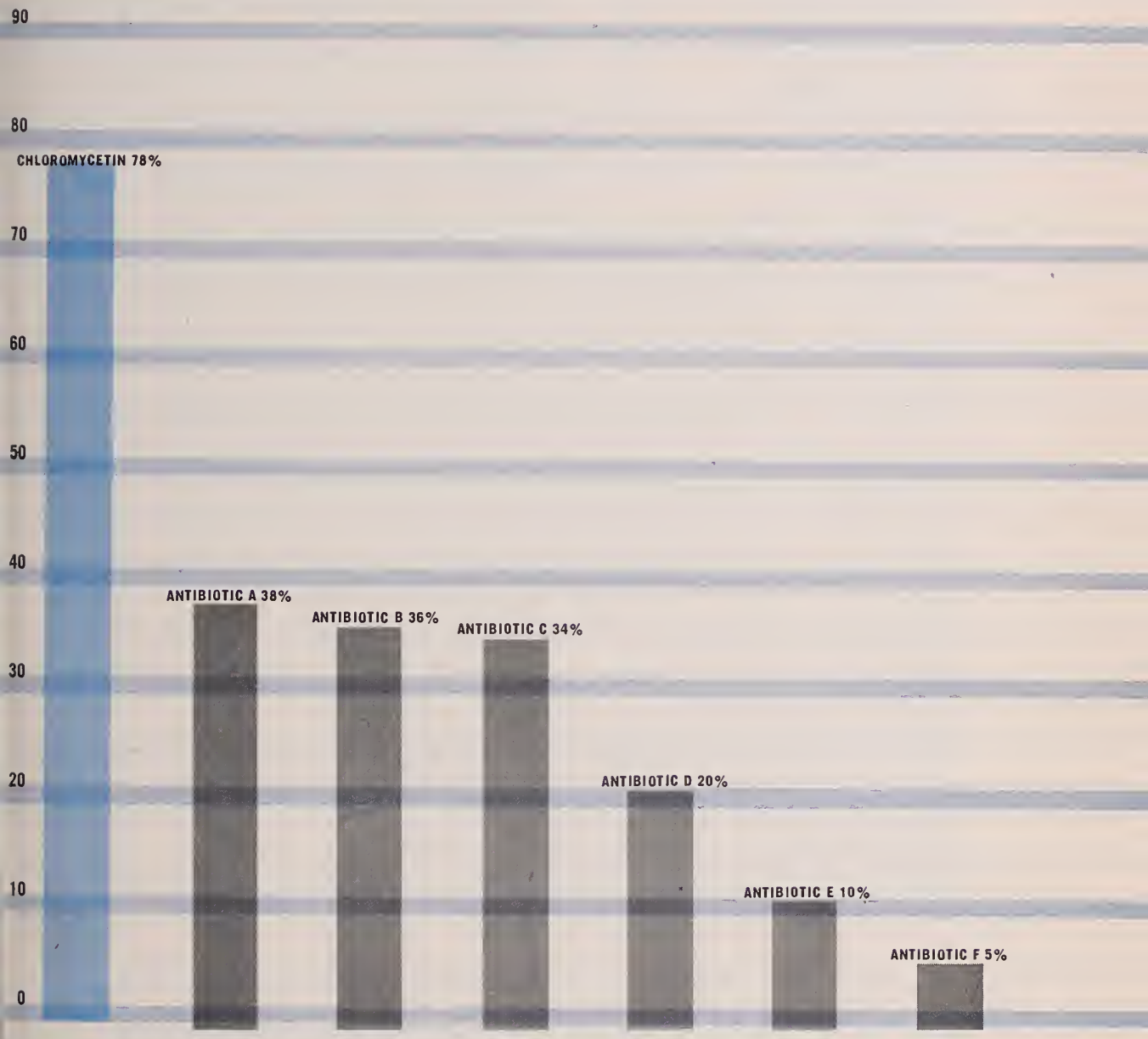
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COMPARATIVE SENSITIVITY OF MIXED PROTEUS SPECIES TO CHLOROMYCETIN AND SIX OTHER WIDELY USED ANTIBIOTIC AGENTS*



*This graph is adapted from Waisbren and Strelitzer.[15] It represents *in vitro* data obtained with clinical material isolated between the years 1951 and 1956. Inhibitory concentrations, ranging from 3 to 25 mcg. per ml., were selected on the basis of usual clinical sensitivity.

The Journal of the Florida Medical Association

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VOLUME XLIV, No. 7 • *January, 1958*

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville Florida, October 23, 1924



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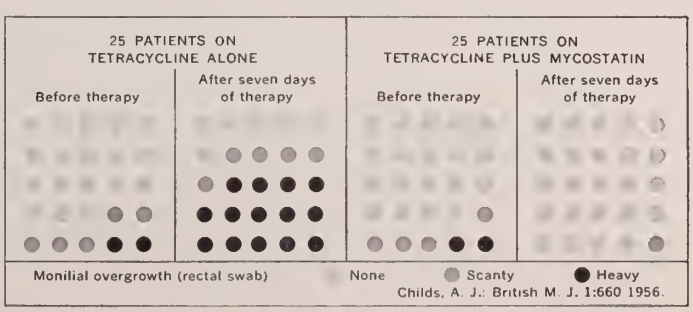
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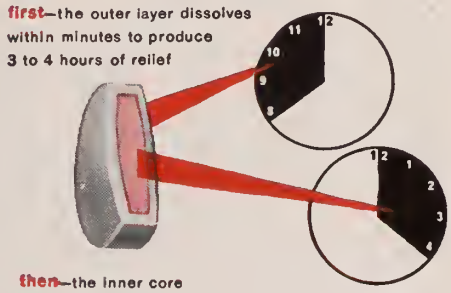
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

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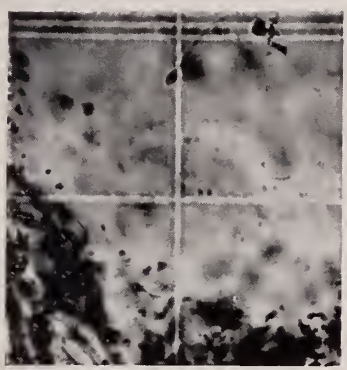
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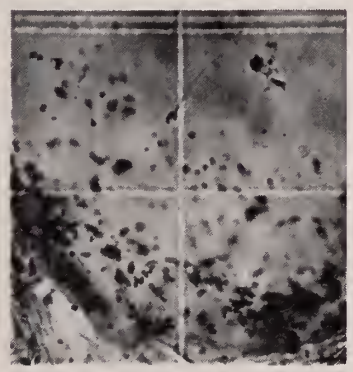
*Goldstein, L. Z.: Obst. & Gynec. *10*:133 (Aug.) 1957.

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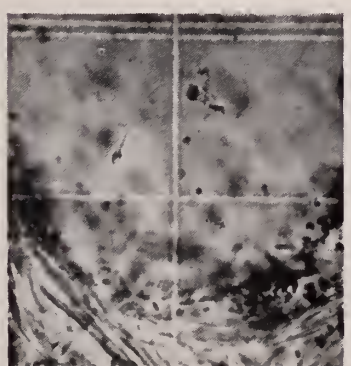
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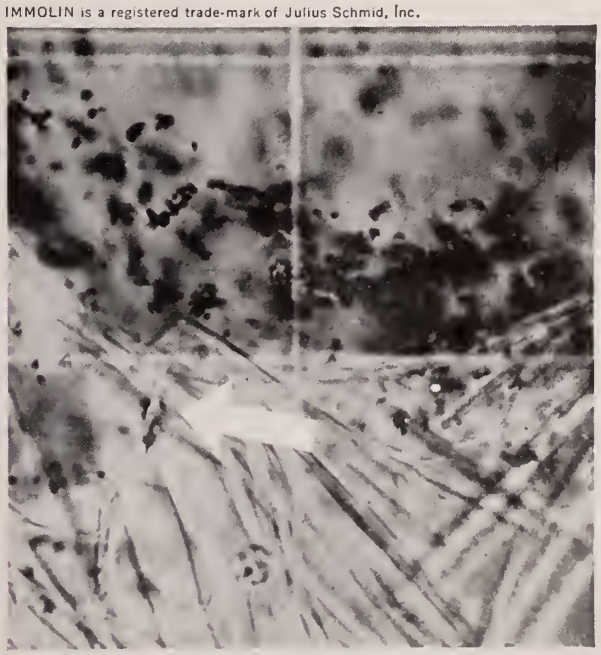
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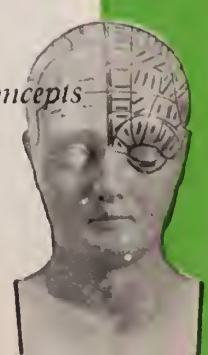
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The Journal of The Florida Medical Association
PUBLISHED MONTHLY

Volume XLIV | Jacksonville Florida, January, 1958 | No. 7

Diuresis and Antidiuresis

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Commonplace though it may be, dropsy is one of the most extraordinary events in human biology, and the reasons why an organism finds it necessary to enlarge itself with brine are far from being understood. It has been stated that sodium retention and therefore edema represent the response of the body to a failing circulation.[1] Contrarily, patients with hypertension excrete sodium with increased facility.[2] Broad generalizations are always dangerous, but with a few notable exceptions the ability of the kidney to excrete salt and water seems to parallel the efficiency of the circulation. The exceptions include principally those few conditions in which excessive amounts of salt-active hormones reach the kidney, but these are seldom confused with hemodynamic disorders.

Edema is always of renal origin in the sense that it cannot occur unless the kidneys excrete less salt than is brought to them. Intake remaining constant, a positive sodium balance is achieved either by reduced glomerular filtration, by increased tubular resorption, or by both. Simple calculations show that even modern clearance technics are incapable of separating these two processes with precision. For example, when the plasma sodium concentration is 140 mEq./l and the glomerular filtration rate as measured by the inulin clearance is 130 cc./min. the daily load of filtered sodium offered to the tubules is about 25,000 mEq., of which less than 200 usually appear in the urine; if the filtered load drops by less than 2 per cent, salt will disappear from the urine provided tubular function remains constant. Conversely, if the rate of glomerular filtration remains constant and that of tubular water resorption diminishes by only 1 per cent, the rate of urine flow will increase by approximately 100 per cent. The important causes of a reduced filtered sodium load are hyponatremia, renal vasoconstriction and disease of the glomerular capillaries while tubular resorption of sodium and of water is regulated in large part by aldosterone from the adrenal cortex and by vasopressin from the neurohypophysis, respectively. Better methods for evaluating glomerulotubular balance are obviously needed.

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Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 6, 1957.

Failure of the Circulation

INADEQUATE CARDIAC OUTPUT.—The common cause of sodium retention is inadequate cardiac output, and in mild cases it may be accompanied by no measurable decrease in the rate of glomerular filtration. Reductions in renal blood flow and glomerular filtration rate are usually apparent, however, and these are not of neurogenic origin. The Pappenheimer group at Harvard has recently advanced some revolutionary ideas concerning the paths by which plasma and red cells traverse their different routes through the kidney,[3] but the impact of these important experiments upon electrolyte metabolism has hardly begun to be appreciated. It is idle, therefore, to speculate about intrarenal events which alter salt and water output, but the clinician can regard them as useful responses, the oliguria of exercise being an obvious example of the way in which the kidney salvages water and electrolytes during circulatory stress. Indeed, the kidney can be likened to a built-in intern ever ready to infuse variable proportions of saline and blood into the peritubular capillaries according to the patient's needs—although we do not yet know precisely how he receives or executes his orders. The fact that the infusion often continues to and beyond the edema level indicates not that the kidney is deranged but merely that the cause of the circulatory disorder cannot be corrected by simple replacement. Myocardial infarction or valvular incompetence requires more fundamental treatment than this.

DIMINISHED BLOOD VOLUME.—The second important cause of circulatory inadequacy is diminished blood volume. It occurs most often in the protein-depletion states of malnutrition,

liver disease and the nephrotic syndrome. After all, the strongest force which determines plasma volume is the oncotic pressure of its own proteins and, when this is reduced, water leaves the blood stream. Again, the means by which this shift informs the kidney that fluid replacement is needed are not known, but hypothetic volume receptors which act upon the neurohypophysis and the adrenal cortex seem somehow to be involved.[4] In any event, edema appears to be useful to the hypoproteinemic patient for it prevents his blood volume from shrinking to dangerously low levels.

Exceptions which prove the rule that edema equates with circulatory failure are found in (1) acute glomerulonephritis wherein the reduced load of filtered sodium is attributed to swelling of the glomerular capillaries and (2) a few rare examples which are as yet quite idiopathic. Mueller, Surtshin, Carlin and White[5] have clearly shown that salt retention is not entirely dependent upon hormonal action.

Treatment

HEART FAILURE.—The antidiuretic process stops if cardiac output can be made equal to the metabolic needs of the body (time, bed rest, digitalis, venesection, antibiotics, vascular surgery). If not, then ways of reducing sodium intake (diet, ion exchange resins) or of increasing renal output (diuretics) must be found. Should reduced sodium intake be ineffective or unacceptable, it is necessary to interfere with the tubular resorption of sodium.

One technic is that of raising the osmotic pressure of glomerular filtrate, and this may be done by giving substances like urea, mannitol, ammonium chloride and Diamox. Urea is unpleasant to swallow, no matter how disguised, and only mildly effective. Mannitol must be given by vein. The action of ammonium chloride is better understood if it is regarded as an indirect way of administering HCl^-, Cl^- being liberated when the liver converts NH^+_4 to urea, for a day or two thereafter the kidney excretes the extra chloride in the form of sodium or potassium salts, but, if renal tubular activity is normal, ammonia then diffuses into the tubular lumen, the excretion of extra Na^+ and K^+ subsides, and within three to five days practically all of the administered NH_4Cl is excreted as such. (It must be remembered that the NH^+_4 ion which comes out in the urine is not the one with which the Cl^- ion was originally combined.) The drug should therefore be administered in short interrupted courses, perhaps 6 to 9 Gm. daily for four or five days to be followed by a brief rest period. It is not very useful by itself, but may potentiate the action of mercury.

Osmotic diuresis due to increased loss of base and water can be induced by inhibitors of carbonic anhydrase, an intracellular enzyme which ordinarily allows the distal tubule to salvage Na^+ by exchanging it for H^+; drugs like acetazolamide (Diamox) force the kidney to use K^+ for this purpose by diminishing the supply of H^+ since they inhibit the enzyme which drives the following reaction to the right — $CO_2 + H_2O \rightarrow H_2CO_3 \rightarrow H^+ + HCO^-_3$. The result is excretion of extra amounts of bicarbonate combined with Na^+ and K^+. Metabolic acidosis of course ensues, but water losses are not often as large as may be desired. At the present time many compounds with similar but more potent actions are being investigated; at least one currently under trial is said to accelerate the excretion of chloride also, thus reducing the possibility of metabolic acidosis and increasing the resemblance of its action to that of a mercurial diuretic. Currently available carbonic anhydrase inhibitors have on the whole been disappointing diuretics.

The xanthines produce an uncertain and inconstant increase in glomerular filtration rate and may therefore be moderately useful when given intravenously about one hour after the administration of a mercurial diuretic.

As a class, the mercurial diuretics act by specifically paralyzing the tubular transport mechanism for salt and water, and are vastly superior to all others. Since the predominant effect seems to be directed against chloride resorption, the frequent and continued administration of organic mercurials may cause metabolic alkalosis characterized by hypochloremia, bicarbonate excess, and a relatively normal serum sodium concentration. This is the condition perhaps most frequently responsible for refractory edema, and the specific remedy for it is ammonium chloride by mouth. It is not to be confused with the so-called "low salt syndrome," nor it in turn with hyponatremic edema. It is probable that the initial error arose from a tendency to assume from low serum chloride estimations that the serum sodium concentration must also be low. As flame photometers came into common use, however, the dissociation became apparent, and accumulated experience has shown that the administration of hypertonic

saline to patients with congestive heart failure is usually disappointing and sometimes harmful.

Given an edematous patient with hyponatremia, there is no easy laboratory method for distinguishing between salt depletion and salt dilution. It is unlikely, however, that a reduction in total body sodium content can coexist with an excess of water; so it is much safer to interpret a low serum sodium concentration in an edematous patient as being due to an excess of water rather than to a deficit of salt. It may occasionally be wise to give 200 to 300 cc. of 3 to 5 per cent saline intravenously to a patient with truly refractory edema, but usually the resulting elevation in serum sodium content is transient, and the blood volume becomes only further expanded. It is obvious that drugs are badly needed which will cause the kidney to release water faster than it does electrolytes; alcohol partially fulfils these requirements because it inhibits the formation of antidiuretic hormone, and there is no reason why it cannot be given in highball form, 3 to 4 ounces of whisky daily in divided doses. Persistent hyponatremia is, however, usually an ominous sign and it may indicate neither salt depletion nor water excess but a general disorganization of the electrical processes vital to cell membrane performance. In this situation nothing can be done.

Finally, ACTH and cortisone-like steroids may be used in refractory cases, but a successful outcome probably depends upon a fortuitous combination of increased glomerular filtration rate and suppression of aldosterone production. Not many physicians have been bold enough to give this approach a thorough trial.

Hypovolemia.—When due to a low hematocrit value, the antidiuretic process is checked by correcting the anemia. The edema associated with protein deficiency of one kind or another, however, is a much more complex problem, and the diuretic measures discussed are relatively ineffective so long as hypoproteinemia persists. The difficulties concerned in raising and sustaining plasma oncotic pressure by artificial means (salt-poor human albumin, dextran) are well known, particularly so in nephrosis where protein is both excreted and destroyed at abnormally high rates. Perhaps the chief indication for salt-poor human serum albumin in the management of the nephrotic syndrome is persistent hyponatremia, a situation which sharply limits steroid responsiveness; it often increases the output of water in excess of salt, raises the concentration of serum sodium and enhances the effectiveness of another course of hormone therapy.

A variety of renal lesions has been found by punch biopsy,[6] the frequency of diabetes mellitus (Kimmelstiel-Wilson lesion) and disseminated lupus erythematosus being notably high. The cause of the hypoproteinemia is unknown, but proteinuria alone does not seem to account entirely for the large total protein deficits. It is tempting to stop treatment when diuresis subsides, but there is a growing belief that hormone therapy should be pushed until proteinuria is controlled as thoroughly as possible. The therapeutic target has therefore shifted from edema to proteinuria, and available statistics suggest that life is prolonged if the proteinuria can be abolished.[7] Probably no two physicians agree as to the choice, dosage, and schedule of hormone therapy, but steroids which can be taken orally are probably just as effective as ACTH, which cannot. I have seen one death from adrenal rupture in a child given large doses of ACTH for three weeks.

Whereas there is fair general agreement that large doses of steroids should be used for two to three weeks, there is much confusion about what to do thereafter. Sometimes a diuresis occurs early in such a scheme, sometimes not until after drug administration has been discontinued. In any event, treatment should not be stopped simply because edema has disappeared, but should be pushed until proteinuria has been controlled for perhaps a month, or until it seems obvious that the proteinuria will not subside. The dangers of sustained hyperadrenocorticism are real, particularly those of latent infection and of collapsed vertebrae; the Cushing state must be carefully weighed against any advantage to the renal lesion which may accrue as a result of long term hormone administration. It appears futile and unwise to maintain a patient in such a state for longer than four months whether the proteinuria is controlled or not, even though all protective adjuvents are also used (K± salts, antibiotics). The usual dosage of cortisone is 300 to 400 mg. daily, and no clearcut advantages for hydrocortisone and other derivatives have yet been shown.

Summary

The kidney responds to an inadequate cardiac output or reduced blood volume by returning increased amounts of brine and blood to the general circulation. If heart function cannot meet meta-

bolic needs, the sodium retention mechanism must be suppressed. Means for accomplishing this objective are discussed. These measures are not likely to be effective when edema is due to hypoproteinemia and its attendant hypovolemia; here treatment should be directed toward protein repletion. In the nephrotic syndrome, hormone therapy should be directed against proteinuria and not discontinued simply because edema has disappeared.

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Diffuse Interstitial Pulmonary Fibrosis: The Hamman - Rich Syndrome

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Interstitial pulmonary fibrosis has been defined by Mallory[1] as a proliferation of fibrous tissue in the alveolar walls or in relation to the lymphatics that run in the walls of air passages and beneath the pleura. It is distinguished from organized intra-alveolar exudate and the scarring resulting from necrotizing lesions of the lungs and healed infarcts. There are many causes and frequently a characteristic interstitial distribution. Thus, the basic lesion in pulmonary sarcoidosis arises in the vicinity of the terminal bronchiole[2] and rarely involves the interalveolar septum to the extent sometimes seen in scleroderma[3] and rheumatoid disease.[4]

This report is concerned with a unique type of diffuse fibrosis of the alveolar wall, first described in 1935 as "fulminating acute interstitial fibrosis of the lungs"[5] and frequently referred to as the Hamman-Rich syndrome in deference to the original authors. Obscure in etiology and supposedly rare, it presents a dramatic picture of progressive interstitial disease of the lungs with an almost invariably fatal outcome which has been the subject of considerable interest in recent years. Despite an awareness of the disorder, it was fully nine years after the original study before another example appeared in the literature;[6] and even up until 1950, they were medical oddities. Since then, however, reports have accumulated in such a fashion as to suggest an increasing incidence, as well as a better general alertness to the existence of such cases. By 1956, Grant, Hillis and Davidson[7] were able to collect 36 examples from the literature in addition to three of their own. Were it not for the fact that individual cases have varied remarkably little from earlier descriptions, notably in a longer total duration of disease, many more reports undoubtedly would have found their way into medical writings. The three cases included in the present study were encountered in a moderate-sized Southern community and its environs over a period of less than one year.

Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 7, 1957.

Clinical Aspects

Diffuse interstitial pulmonary fibrosis (the Hamman-Rich syndrome) is usually observed in mature adults, although several reports have concerned children.[8,9] White and Negro, male and female may be affected.

The entire course of obscure, relentlessly increasing respiratory insufficiency is dependent upon changes occurring at the alveolar-capillary level. Dyspnea and cough dominate the clinical picture, though they may be preceded for an indefinite period by a vague feeling of ill health

and fatigability. The breathlessness, at first mild and noted only with exertion, progresses at a variable rate and eventually is experienced at rest. Even in long-standing cases, however, lying flat usually does not increase the difficulty. Cough may be severe and paroxysmal, but tends to be nonproductive, except in the presence of secondary infection. Other symptoms consist of an occasional small hemoptysis, pain in the chest and loss in weight.

Respiratory difficulty is quickly confirmed by the appearance of the patient. Breathing is rapid and shallow, and intense cyanosis and clubbing are evident in advanced instances. Despite obvious distress, examination of the chest usually reveals a paucity of findings. This disparity between symptoms and signs may be attributed to the fact that the major pathology is interstitial and therefore associated with a minimum of physical findings as is primary atypical pneumonia. Inspiratory, crackling rales, particularly in the lung bases, are frequently the only abnormality.

Fever, significant production of sputum, leukocytosis and acceleration of the sedimentation rate occur, as a rule, only when the course is complicated by intercurrent or terminal pyogenic infection. Such episodes are not unusual and constitute severe medical emergencies in the presence of an already diminished respiratory reserve.

Since the predominant fibrosis lies within the alveolar wall, rather than the bronchiole, expiration is not prolonged, the timed vital capacity fails to indicate air trapping (case 2), and significant emphysema seldom develops. Alteration of the relationship of the pulmonary capillaries to the alveolar lumen produces a typical "alveolar-capillary block." Thus, studies[10] have shown normal ventilatory function with low arterial oxygen saturation. In addition to the diffusion defect, the collagenous hyperplasia reduces the size of the vascular bed, resulting in increased resistance in the pulmonary circuit and accentuation of the pulmonic second sound. Right heart failure, intractable systemic congestion and edema may ensue. Secondary polycythemia may contribute to the heart failure and a tendency toward thrombosis.

The roentgenologic features[11] are characteristic but nonspecific. An initial slight diffuse prominence of the lung markings is easily overlooked, even in the presence of symptoms. With moderate progression, the linear shadows are better seen, and there is a superimposed nodularity. The sharp definition of these generalized reticulonodular densities may be lost in advanced cases. The picture then is one of a diffuse mottling. Eventually diaphragmatic motion is limited. It may be difficult to outline the cardiac silhouette in some instances; in others, it is possible to determine right ventricular enlargement. Hilar adenopathy is usually inconspicuous; and although postmortem examination frequently reveals small amounts of pleural fluid, this change is seldom pronounced in roentgenograms.

Aside from a single case[12] diagnosed antemortem by lung biopsy and effectively treated with cortisone, the disease has been uniformly fatal, the total duration of the illness varying in extreme cases from 31 days[5] to nine years.[13] Although it was originally described as a fulminating illness, it has subsequently become apparent that in subacute and chronic cases the patients living several years far outnumber those having the acute variety. In some of the clinically acute cases the condition may actually represent end stages of a gradual subclinical exhaustion of respiratory reserve.

The possible existence of mild nonprogressive and localized forms of the disease has been suggested repeatedly,[7,13,14] but proof of the occurrence of these variants has not been forthcoming. It appears that the pathologic process, once set in motion, continues unabated until the death of the organism.

Pathology

Definitive diagnosis is dependent on pathologic study of lung tissue (thoracotomy or autopsy). Grossly the lungs are heavy and firm, and they sink in water. The pleura is frequently uninvolved, but may be covered with small blebs of lung tissue surrounded by tiny depressed scars, giving a cobblestone appearance. The cut surface is dry except in the presence of edema or infection.

The microscopic appearance of the lungs is by far the most distinctive feature of the disease. Throughout all lobes, there is striking thickening of the alveolar wall due to pervasion by a profuse fibrous reaction. This varies in different patients, and even in different sections of the lung in a single case, from a vigorous proliferation of young fibroblasts to the deposition of enormous quantities of hyalinized connective tissue. In cases of recent origin, fibroblastic proliferation predominates, while in others of longer

standing, this component is overshadowed by the presence of collagen. In all instances, however, both types of change can be found on careful search, reflecting continued activity of the underlying process.

Intermingled with the fibrous elements, varying numbers of lymphocytes and monocytes, and occasionally a significant number of eosinophils, can be seen. Polymorphonuclear leukocytes may be present, but are seldom prominent, and the absence of stainable bacteria is of critical importance.

Alveolar spaces are encroached upon by the massive interstitial reaction, frequently appearing as mere slits in a mass of connective tissue. In areas where they are obliterated, one sees only a sheet of hyalinized fibrous tissue. Alveolar lining cells frequently undergo cuboidal hyperplasia, occasionally to such an extent as to give a pseudoglandular appearance. These cells may desquamate, and an eosinophilic hyaline membrane can often be seen in close apposition to the alveolar walls. Characteristically, intra-alveolar exudate does not organize.

Pulmonary arterioles not infrequently show thickening, but it is not settled whether this is a primary change or the result of long-standing pulmonary hypertension.

Diagnosis

When confronted with an obscure respiratory illness characterized clinically by dyspnea, cough, cyanosis, a paucity of physical findings and a relentless, unresponsive course, radiographically by bilateral, eventually diffuse mottled or reticulonodular shadows, and physiologically by a restrictive ventilatory defect with alveolar-capillary block, diffuse interstitial fibrosis (the Hamman-Rich syndrome) should be suspected. A multitude of other disorders present certain similarities, however. Those most commonly requiring differentiation are pulmonary edema, interstitial pneumonia, sarcoidosis, tuberculosis and the pneumoconioses, while occasional confusion may result from lymphangitic carcinomatosis, lymphoma, leukemia, the collagen disorders, bronchiolar cancer, fungus disease and the histiocytoses. Conventional methods should, of course, be exhausted in an effort to establish an etiology in such situations, but are frequently disappointing in disease confined to the pulmonary interstitium. The subsequent plan of action then lies between an uncertain course of continued observation, on the one hand, or open thoracotomy and lung biopsy on the other. Too often, the decision on which course to pursue is affected by misconceptions regarding the dangers of surgical biopsy and economic factors. The procedure entails minimal risk in the hands of a competent surgeon, provides a definitive diagnosis and frequently proves less drastic than prolonged temporizing with indeterminate pulmonary disease.

Report of Cases

Case 1.—A 52 year old white male barroom proprietor first became ill in February 1953, with grippal symptoms necessitating hospitalization. Examination disclosed many crepitant rales over both lung fields but nothing else of significance. A posteroanterior roentgenogram of the chest with the patient in the erect position (fig. 1) showed prominent markings throughout both lungs. He was treated symptomatically for a week and discharged as improved. Thereafter, exertional dyspnea became apparent. This gradually increased and became associated with a persistent, nonproductive cough, fatigability, insomnia, anorexia and loss in weight. By Dec. 20, 1954, his weight had decreased from an average of 195 pounds to 166 pounds. He had always smoked heavily, but finally discontinued smoking because it seemed to exaggerate the pulmonary symptoms. At no time did he experience hemoptysis or fever.

Because of the progressive course, the patient was hospitalized for further study in December 1954. The only physical abnormalities noted were generalized crepitant rales and an accentuated pulmonic second heart sound. There were no cyanosis, distention of neck veins, heart murmurs, or peripheral lymphadenopathy. The blood pressure was 126 systolic and 80 diastolic. Roentgenographic studies of the chest revealed much exaggeration of markings throughout both lungs; the heart size and configuration were normal. Maximum breathing capacity was 48.1 liters per minute (predicted normal, 106 liters), and vital capacity was 1.43 liters (predicted normal, 3.57 liters). The sedimentation rate was 44 mm. per hour. The total serum proteins were 6.3 Gm. with 3.3 Gm. of albumin and 3.0 Gm. of globulin. The complete blood count, urinalysis, stool examination, serologic test for syphilis, fasting blood sugar, blood nonprotein nitrogen, serum cholesterol, carbon dioxide combining power, serum chlorides, electrocardiogram, cholecystogram and upper gastrointestinal series were normal.

The patient was subsequently followed as an outpatient. He was digitalized, and a low salt diet was ordered. On Jan. 20, 1955, hydrocortisone was begun with a daily maintenance oral dose of 60 mg. Mild symptomatic improvement occurred, although varying degrees of cyanosis were noted. On April 8, it was observed that his color was good and that the dyspnea and cough were better. On that day hydrocortisone was discontinued, and Meticorten, 20 mg. daily, divided into four equal doses was prescribed. His condition abruptly became worse. On April 22, because of extreme dyspnea and cyanosis, Meticorten was increased to 40 mg. daily without noticeable benefit. Hydrocortisone was then substituted; however, he became progressively worse and was finally hospitalized again on April 27. On examination, he was extremely dyspneic and cyanotic even in an oxygen tent, and there were numerous inspiratory crackles throughout both lungs. The pulmonic second sound was accentuated, the pulse rate was 120, the temperature was 101 F.(R), and the blood pressure was 136 systolic and 82 diastolic. Despite therapy with oxygen, Cedilanid, Mercuhydrin, antibiotics, Alevaire nebulization, hydrocortisone, 20 mg. every four hours, and Orthoxine, the patient died on April 28, after an illness of slightly over two years total duration.

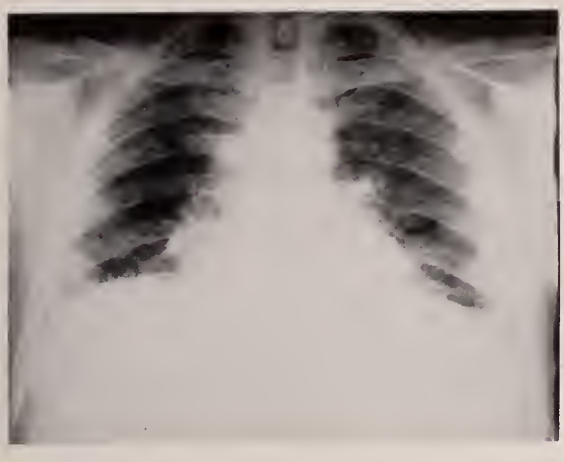


Fig. 1., Case 1.—Posteroanterior chest roentgenogram showing prominent markings and diffuse nodulation.

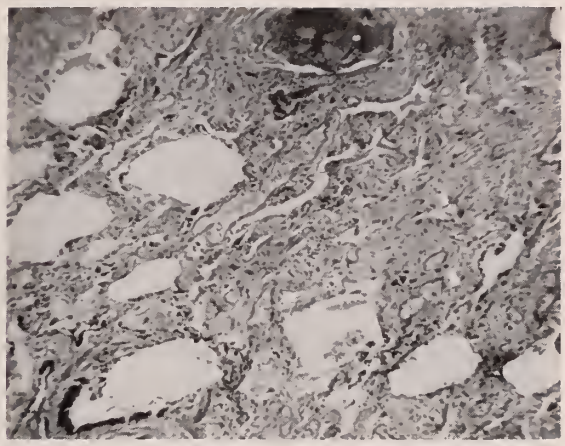


Fig. 2., Case 1.—Microphotograph (66X) of autopsy specimen of lung revealing diffuse dense interstitial sclerosis. There is minimal fibroblastic reaction.

AUTOPSY. — Pertinent findings were limited to the thorax. No free fluid or pleural adhesions were present. The pleural surfaces were coarsely nodular, and there were moderate amounts of watery, frothy fluid in the airways. No bronchiectasis was noted. The pulmonary artery and veins appeared normal. The cut surface of the lung was firm and granular, and moderate amounts of watery fluid could be expressed with slight pressure. The hilar nodes were slightly enlarged. Anthracotic pigmentation was noted in both the pulmonary substance and lymph nodes. Mediastinal structures appeared normal, and examination of the heart revealed no abnormalities.

Microscopic findings (fig. 2) consisted of a dense interstitial sclerosis, minimal fibroblastic reaction and superimposed acute diffuse pneumonia.

Case 2.—A 48 year old white male cab driver was first seen in the office on Oct. 12, 1955. For about two years, he had experienced increasing dyspnea, dry cough and weakness. He was still able to drive his cab without difficulty at that time. No history of pain in the chest, wheezing, hemoptysis or occupational exposure could be elicited.

Physical examination revealed mild cyanosis. The blood pressure was 150 systolic and 90 diastolic, the respiratory rate was 24, and the pulse rate was 80. There were many inspiratory crackling rales in both lung bases, anteriorly and posteriorly. No other physical abnormalities were noted. A roentgenogram of the chest (fig. 3) disclosed diffuse mottled densities bilaterally, especially in the parahilar regions and medial bases; the heart appeared normal. The total vital capacity was 2.1 liters with a three second volume of 2.0 liters (95 per cent of total). The blood count and urinalysis gave normal results.

The patient was hospitalized, and on Jan. 17, 1956, open lung biopsy was performed. The entire right lung had a faintly nodular consistency. Examination of the hilum revealed no unusual lymph nodes. Microscopic study of the biopsy specimen (fig. 4) disclosed a prominent loss of alveolar structure associated with a decided increase in interstitial fibrous connective tissue. There were irregular scattered foci of stromal round cells. The remaining alveolar spaces were lined with a single layer of hyperplastic low columnar cells, and the lumina contained aggregates of macrophages and sloughed lining cells.

On January 30, the administration of cortisone was begun with an initial daily dose of 300 mg. This was gradually reduced to a maintenance level of 100 mg., which has been continued until the present time. By Feb. 20, 1956, there was moderate subjective improvement in dyspnea, cough, appetite, strength and general sense of well-being; however, the vital capacity showed no change from previous values, and there was no



Fig. 3., Case 2.—Posteroanterior roentgenogram of chest showing diffuse mottled densities bilaterally, especially in the parahilar regions and medial bases.

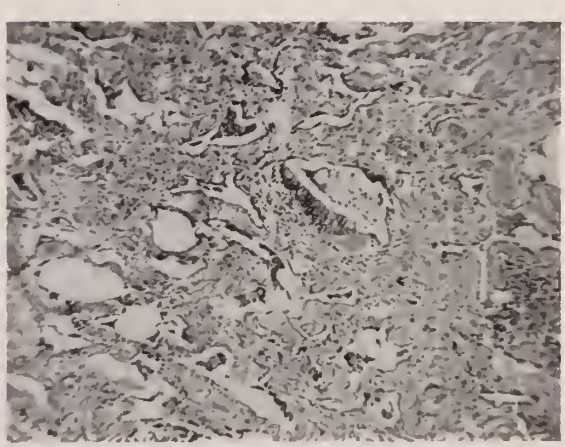


Fig. 4., Case 2.—Microphotograph (152X) of lung biopsy specimen revealing prominent loss of alveolar structure associated with decided increase in interstitial fibrous connective tissue and scattered foci of stromal round cells.



Fig. 5., Case 3.—Posteroanterior roentgenogram of chest. There are diffuse reticulonodular densities throughout both lungs, especially in the bases.



Fig. 6., Case 3.—Microphotograph (66X) of biopsy specimen of lung showing severe interstitial fibrosis with round cell infiltration.

radiographic improvement. Although cortisone was continued, the initial subjective improvement was gradually lost. On May 7, because of increasing dyspnea, cough, a four pound gain in weight and a trace of ankle edema, digitalis and a low salt diet were added to the regimen, as well as intermittent use of mercurial diuretics. Periodically, antibiotics have been required for febrile episodes and purulent sputum.

Despite all therapy, the patient's condition has steadily deteriorated, and there has been a gradual progression of the radiographic densities in the lungs. Periodic search has failed to elicit evidence of involvement of organs other than the lungs; on December 11, an L.E. study on peripheral blood gave negative results. At the time of this writing, the patient is still living, but unable to work and even has difficulty caring for his body needs because of severe dyspnea.

Case 3.—A 62 year old white woman was hospitalized on May 12, 1955. The presenting illness began around March 1954 with cough, dyspnea and fever, and she was told she had a pulmonary disease consistent with sarcoidosis. Subsequently, there was a gradual 27 pound loss in weight and several febrile episodes. Four days before admission, there developed an elevation of temperature to 103 F., orthopnea and purulent sputum, and she was treated with tetracycline without benefit.

Physical examination revealed cyanosis, a pulse rate of 88, a blood pressure of 100 systolic and 60 diastolic, and a respiratory rate of 24. Other findings included grade II apical and aortic systolic murmurs, cataract of the left eye, aphakia of the right eye, a barely palpable liver and pea-sized left supraclavicular and axillary nodes. Fluoroscopic and radiographic study of the chest (fig. 5) disclosed small, diffuse, linear and nodular densities throughout both lungs, especially in the bases. A hemogram was as follows: red blood cells 3.0 million, hemoglobin estimation 12.3 Gm., white blood cells 8,550, 66 per cent polymorphonuclear leukocytes, 32 per cent lymphocytes and 2 per cent eosinophils. The corrected sedimentation rate was 47 mm. per hour. The total serum proteins were 7.5 Gm. per hundred cubic centimeters with 3.6 Gm. of albumin and 3.9 Gm. of globulin. Urinalysis showed 1 plus albuminuria, but nothing else of note. Roentgenograms of the hands were consistent with minimal osteoarthritis. The fasting blood glucose, blood urea nitrogen, serologic test for syphilis, blood culture, sputum studies for tubercle bacilli and tuberculin skin tests gave normal results.

Oxygen was administered for dyspnea. Initial temperature elevations as high as 104 F. gradually subsided over a 12 day period under the influence of chloramphenicol, and the patient was discharged from the hospital on May 28. Roentgen examination revealed some clearing of the pulmonary shadows; however, diffuse reticulonodular shadows remained. At the time of discharge she was receiving cortisone, which was continued until July 9, with no apparent benefit. There was no particular difficulty in discontinuing the drug.

In May 1956, the patient was studied at a diagnostic center where multiple examinations, including three preparations for L.E. cells, liver function studies and a hemogram were normal. Surgical lung biopsy was then carried out on the left in an effort to clarify the nature of the diffuse pulmonary process. Study of the biopsy specimen (fig. 6) revealed severe interstitial fibrosis with some round cell infiltration; the changes were almost exclusively of the chronic variety, there being little or no fibroblastic reaction. There were no tubercles of sarcoidosis. She was discharged with instructions to take cortisone, 50 mg. daily.

While taking cortisone, the patient became febrile. There was no response to erythromycin and Terramycin. A petechial rash developed, and she was again hospitalized on June 18.

On examination, the patient was pale and disoriented, and there were fine petechial hemorrhages over the trunk and extremities. Moist rales were present throughout both lungs. Blood studies revealed red blood cells 2.65 million, hemoglobin estimation 8.8 Gm., white blood cells 4,800, 2 per cent eosinophils, 71 per cent polymorphonuclear leukocytes, 24 per cent lymphocytes and 3 per cent plasma cells. The bleeding time was three minutes, 30 seconds, and the clotting time, six minutes. Platelet counts ranged from 30,000 to 75,000. The prothrombin time was 19 seconds (control, 12 seconds). There was partial clot retraction after 24 hours. The Coombs tests, direct and indirect, gave negative results. Study of a bone marrow aspirate revealed numerous large cells interpreted as giant megakaryocytes.

The patient initially responded to oxygen, chloramphenicol, digitalis, intravenous fluids and transfusions of whole blood, and the petechiae gradually faded. On July 17, however, she again became febrile, progressively weaker and disoriented, and finally died on July 30. A postmortem examination was not performed.

Comment

The first two cases seem acceptable as examples of the Hamman-Rich syndrome of the chronic variety, but certain aspects of the third case render its inclusion subject to question. Anemia, thrombopenia and bone marrow changes have not been associated features in previously

reported cases. The case is otherwise typical. Inclusion of such borderline examples and comparisons with other situations having certain similarities may lead to broader concepts and perhaps an appreciation of a clinical spectrum. The most obvious direction indicated by this line of reasoning is to a consideration of the collagen disorders (vide infra).

Lung biopsy, which was performed on the last two patients, proved relatively innocuous, even in the face of severe respiratory insufficiency; and while it unfortunately failed to alter significantly the eventual outcome, the insight it provided more than justified it to all concerned. Utilization of the procedure at an earlier, presumably more proliferative stage, may have resulted in a more satisfactory response to steroid therapy.

Treatment

Therapy, in general, has been disappointing, most information on the subject having emphasized its limitations and pitfalls. The obscure pathogenesis, difficulty in establishing a diagnosis and fibrous nature of the process have all contributed to the problem.

It might be anticipated that the adrenal steroids would be beneficial. While they have been used with success in isolated instances of recent onset, shortcomings have been apparent. In one acute example, reported by Peabody, Buechner and Anderson,[13] remarkable symptomatic and radiographic clearing resulted from the use of corticotropin and cortisone. A few days after cessation of therapy, however, there was a violent recurrence of symptoms and a return of abnormal roentgen shadows. The patient died within 24 hours despite reinstitution of massive steroid therapy. Precipitous deaths in two other patients with more chronic illnesses under similar circumstances of dosage manipulation prompted the writers to recommend extreme care in the use of the drugs. Pinney and Harris[12] described an acute case in which the diagnosis was established antemortem by lung biopsy. A sustained remission was produced by the use of continuous cortisone therapy. They emphasized the need for early diagnosis and the institution of therapy while the reaction is still predominantly fibroblastic. Success is obviously dependent on the use of an effective agent before significant sclerosis has occurred, a fact which probably accounts for the universally poor results obtained by others. The value of surgical lung biopsy in this connection is obvious.

Our experience with three cases of the chronic variety parallels the general experience of others. In all, the patient failed to improve significantly on adrenal steroids. Moreover, the abrupt downhill course in the first case coincided with the substitution of a different type of preparation for the steroid already in use and strongly suggested to all observers, including the patient's family, that the change had something to do with the outcome.

While the lack of improvement in the face of an established fibrous process is understandable, the mechanism responsible for the exacerbation of symptoms that can occur following alteration of the dosage is less clear. The role of pituitary insufficiency, atrophy of the adrenals and secondary infection seems unlikely.[13] A more plausible explanation pertains to the limited respiratory reserve which these patients exhibit. In such a borderline state, a minor insult, for example, manipulation of a therapeutic agent, may be all that is required to upset irreversibly the already precarious balance in favor of complete respiratory insufficiency.

In any event, corticotropin and cortisone should not be administered indiscriminately for the treatment of diffuse indeterminate pulmonary disease. A correct diagnosis is desirable, and it should be appreciated that established fibrosis, which predominates in the majority of the cases of the Hamman-Rich syndrome, precludes an effective response to steroids. Once they are instituted, extreme caution should be exercised in any adjustment of dosage.

Etiology

Speculation on the etiology of the Hamman-Rich syndrome has run the gamut of most of the common causes of respiratory disease. A bacteriologic origin seems unlikely. No organism has been consistently isolated from the sputum, and an absence of stainable bacteria in pathologic specimens has been a universal experience. Similarly, history has not disclosed exposure to noxious inhalants.

Several cases reported have had interesting genetic implications. Peabody, Peabody, Hayes and Hayes[15] observed the disease in identical twin sisters. Since they had led widely separated lives for at least 25 years prior to the onset of their illness, the presence of some inherent tendency, rather than an exogenous factor, is likely. The disorder has been reported in brothers,[13,16] who also had different environmental back-

grounds.* Thus, of the approximately 39 cases which have been reported from various parts of the world, a familial incidence has been apparent in four, a situation which is difficult to attribute to chance.

One of the most popular hypotheses is that which proposes a viral etiology. The similarity of the pathologic changes of acute interstitial pneumonia of viral origin to some of the more acute examples of the Hamman-Rich syndrome is striking, and it has been suggested that such a recurrent interstitial pneumonitis could initiate a diffuse fibrosis.[17] Heppleston,[18] on the other hand, has pointed out that the lesions in interstitial pneumonia have a distinctly focal distribution centered on the bronchiole, unlike that found in diffuse interstitial fibrosis. He further emphasized that in acute interstitial pneumonia there is disruption of the elastica, which in diffuse interstitial fibrosis remains intact. Inclusion bodies have never been demonstrated, and a virus has never been isolated. Despite these objections, however, a virus etiology cannot be disregarded.

The presence of eosinophils, a finding emphasized by some workers,[5] is compatible with an allergic etiology. More tangible evidence of such a connection is provided by reports of toxic reactions that have occurred under the influence of certain antihypertensive preparations. Morrison[19] described three patients in whom changes in the lung developed which were probably a complication of hexamethonium therapy for hypertension. All three had been improving satisfactorily, radiologic signs of heart failure had disappeared, and they had returned to active life when dyspnea suddenly developed. In contrast to previous cardiac dyspnea, it was relieved by lying flat. Roentgen examination of the lungs revealed bilateral opacities, and necropsy in one of the cases showed "extensive cornification." In a report of the toxic reactions of Hyphex, a combination containing l-hydrazinophthalazine and hexamethonium, Morrow, Schroeder and Perry[20] commented on the frequent occurrence of collagen disease on the one hand and a disorder resembling the Hamman-Rich syndrome on the other. Thus, there were five deaths from a condition identical pathologically with "acute interstitial fibrosis of the lungs."

The similarity between the microscopic appearance of the Hamman-Rich syndrome and some of the pulmonary manifestations of the diffuse collagen disorders has been the basis for the intriguing proposal that the former may represent a collagen disease localized to the lungs. Practically identical histologic changes have been observed in the lungs of patients with scleroderma,[3] rheumatoid disease[4] and dermatomyositis.[21] Localization to one system, namely, the locomotor apparatus, has been the rule in rheumatoid disease, and only in recent years has the frequency of visceral lesions been appreciated. Predominant or exclusive involvement of some other system, such as the lungs, is not beyond the realm of imagination.

In summary, it may be stated that the etiology of diffuse interstitial fibrosis is unknown. One or more precipitating agents may be operative on a background of inherited predisposition to produce a histologic pattern not unlike that seen in the lungs of certain examples of the diffuse collagen diseases.

*One of the cases of Wildberger and Barclay[16] had been previously reported in detail,[13] note being made then that the brother was ill with a clinically indistinguishable illness.

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Discussion

Dr. Jack Reiss, Miami: Dr. Anderson and Dr. Emmel are to be congratulated on the presentation of this excellent paper. They reported three new cases of this unusual condition which they observed in less than one year. To date approximately 46 authenticated cases have appeared in the literature. Most of them have been reported since 1950. There are probably many more cases in the autopsy files of hospitals that have not been reported. The true incidence of the disease is therefore unknown.

At the Veterans Administration Hospital in Coral Gables, there were 2,400 autopsies during the past 10 years. Four cases of Hammon-Rich syndrome were diagnosed, all of them in the years 1953 and 1954. They were not reported.

Of all the problems in pulmonary diseases, there is probably none more challenging than the differential diagnosis of diffuse pulmonary lesions. The diagnostic possibilities are endless, clinical findings tend to be obscure, and seldom are the usual laboratory tests of any help.

The diagnosis may be suspected on clinical grounds, but ultimately hinges upon the demonstration of the more or less typical microscopic picture in sections obtained from lung biopsy or at autopsy. Biopsy should be performed early when treatment might be most effective. Two essential requirements are the absence of any demonstrable etiologic organism and the lack of a significant acute inflammatory response.

The various facets in the etiology of the disease have been well covered by the authors. There is no assurance that there is a single cause. There is no question that the problems relative to this disease will be resolved only by studying the pathogenesis of this syndrome.

The management of this disease has been universally disappointing. The steroids may be useful in the acute fulminating cases and in those cases diagnosed early. In recent years publications indicate that a basically similar condition can be rapidly fatal or slowly progressive over a few years. Clinical features of great interest are the remarkable clearing of the lungs with ACTH or cortisone therapy and the equally remarkable recrudescence of the process on cessation of such therapy. Once steroids are instituted, a permanent maintenance might be the safest course to follow. Patients with chronic disease should probably not receive the steroid since the long-established fibrosis precludes fibrolysis.

I thank the authors for the privilege of discussing their stimulating paper.

Preliminary Report on Treatment Of Mongoloids

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During the past few years there has been a renaissance of interest in mongolism. This has been evident from the numerous publications on this subject. Comprehensive studies by Benda,[1] Gilston[2] and Levinson, Friedman and Stamps[3] have described this disease entity, its variations and relationship to other diseases. Penrose[4] and Friedman[5] have discussed the etiology of mongolism, while Smith and McKeown[6] have described the prenatal growth of mental defectives. The morphologic study of a mongoloid newborn and related genetic problems have been described by Pecchiai and Bencini.[7]

The metabolism of mongoloids, with special attention to cholesterol and lipoprotein levels in these children, has been clarified by Benda and Mann.[8] There has been further delineation of this problem as to iodine uptake by Friedman,[9] and other types of metabolic changes have been discussed by Simon, Ludwig, Gofman and Crook.[10] Pennacchietti and Ferrio[11] have reported a fairly large series of electrocardiographic studies on mongoloids with special emphasis on cerebral development while the occurrence of convulsions in mongoloids has been described by Schachter.[12]

The problem of investigation in this disease entity has been outlined by Prichard, [13] but other than the report of Tatafiore[14] in 1952, the treatment in this disease has not been thoroughly discussed. This does not imply any lack of interest but rather a necessity for greater effort towards vigorous attempts to correct this abnormality in its early phase.

These publications do not constitute a survey of the literature on this subject. They demonstrate, however, that a tremendous amount of work has been done in this field and that continued progress is being made.

The purpose of this report is to present our preliminary results obtained in the treatment of mongoloid children with young calf pituitary extract. This type of therapy was first suggested by Benda.[1] Initial dosage has been 1 grain daily, increased at two week intervals until tolerance of 4 grains is reached. Tolerance is indicated by hyperirritability. Treatment is started as early as possible, in some instances as early as five days. We use Armour's young calf pituitary. The powder is mixed with milk or food and is given at the longest possible intervals. There has been no

problem in administration or tolerance. The only untoward reaction has been hyperirritability, which disappeared when the dose was decreased.

Method

Twenty-six monologoid children have been studied with this type of therapy. The majority of these children have been under the care of their private physicians and have been followed carefully by us, with special attention to mental and physical development over long intervals of time. Several of these children have been started on treatment below six weeks of age and a number of them between the ages of two and eight months. Clinical judgment of the degree of involvement at birth has been given to us by the attending physician. In the majority of these infants psychometric testing was done with Cattell's infant intelligence scale.

Results

Our observations should be interpreted only as preliminary impressions and not as completely controlled observations. Three patients appear to have developed a normal I. Q. range at the present time and have lost some of the mongoloid stigmas. In the remaining cases studied the results have varied from no real degree of I. Q. improvement to significant degree in others. Results as to I. Q. development and clinical impressions are summarized in table 1. Improvement is charted in table 2.

Report of Cases

Case 1.—A premature infant, delivered at eight months' gestation, was thought by the pediatrician to be moderately mongoloid at birth. Medication was started at seven weeks of age, consisting of 1 grain of calf pituitary, and was gradually increased to 3 grains by the time the child was four months old. The I. Q. rating at one year was 72. He has had several respiratory infections, has gained weight poorly, has poor muscle tone and has not developed too well physically. Mongoloid stigmas are still prominent, but it is thought that he is developing better than the average mongoloid according to the physician.

Case 2.—A full term child, whose birth weight was 8 pounds and 6 ounces, appeared to be moderately mongoloid. Treatment was started at seven weeks of age, consisting of 1 grain of young calf pituitary, and was increased to 3 grains at the end of two and one-half months. The child has developed extremely well. At the age of eight months most of the mongoloid stigmas had disappeared except the flat bridge of the nose and the eye signs. The estimated I. Q. at eight months was 110. He was tested at 14 months with an estimated I. Q. of 105. At 18 months the I. Q. rating was 98. The child has made excellent progress. He says 30 to 40 words and has had only one respiratory infection and no serious illnesses. He is an exceptionally alert child and is developing rapidly.

Case 3.—An infant, whose birth weight was 6 pounds and 8 ounces, appeared to be a moderately severe mongoloid. Medication was started at five weeks of age. The patient has developed rapidly. He sat at five months, stood at eight months, walked at 11 months, and began to say words at 13 months. At two years of age, he had an I. Q. rating of 94 and had lost practically all of his mongoloid stigmas except the eye signs. At 30 months the I. Q. rating was 92. On roentgen examination, the hand appeared to be within normal limits.

Case 4.—A premature infant, delivered at eight months' gestation and weighing 5½ pounds at birth, apparently was only slightly mongoloid. He gained weight rapidly. Treatment, started at six weeks of age, consisted of 1 grain of young calf pituitary and was increased to 4 grains by three months of age. He has had no respiratory infections. The mongoloid stigmas appear to be fading. At six months of age his I. Q. rating was 105; at nine months of age the rating was still estimated to be 105. At one year the I. Q. rating was 100. The child seems to be most alert and within normal limits in every way.

Case 5.—A child, delivered at term with a birth weight of 7 pounds and 2 ounces, was a moderately severe mongoloid, as diagnosed by the pediatrician. One grain of young calf pituitary was started at five weeks of age and increased to 3 grains by the end of the third month. He appeared to become more alert almost immediately and at four months of age had an estimated I. Q. of 86. At eight months the I. Q. was estimated at 88. Some of the mongoloid stigmas appear to be fading although appearances are definitely mongoloid.

Case 6.—A full term child, with a birth weight of 6 pounds and 4 ounces, appeared at birth to be mildly mongoloid. She was given treatment, consisting of 1 grain of pituitary at three weeks of age, which was increased to 3 grains by the end of the second month. She has had no skin infections or respiratory infections. The child was developing well at seven months and had an estimated I. Q. of 78. At one year the I. Q. was estimated at 80.

Case 7.—A full term infant weighed 6 pounds and 4 ounces at birth. A congenital anomaly of the heart was present. The diagnosis was severe mongolism. The child was given treatment at six weeks of age, consisting of 1 grain of pituitary, which was increased to 3 grains a day by the third month. The child has had no infections and appears to be developing well, although at five months the estimated I. Q. is only 58. Most of the mongoloid stigma is still present.

About 25 patients, ranging in age from 16 months to four years, have been treated in various cities. The mothers of most of the patients think they see varying degrees of improvement, but we are not optimistic about the results in them.

A Pensacola pediatrician has been treating three children, one of whom was started on treatment at five days of age and is now a little over one year of age. The physician thinks that the muscle tone may be a little above the average for the untreated monogoloid. The physical activity is definitely retarded for the age. She has almost chronic respiratory infection. The I. Q. rating now is 71, which classifies this child as a mild mental defective. The I. Q. rating at the age of four months was 73. Treatment may have been worthwhile in this case, but it is still questionable. The next child, a severe mongoloid whose treatment was started at five months of age, has shown no improvement whatsoever. The third child reported on by this physician received treatment beginning at four weeks of age and is four months old at

Table 1. — Summary of I. Q. Development and Clinical Impressions Expressed in Per Cent of Change

Case	Age Medication Started	Physical Appearance	Activity	Learning	Social Response	Skin Infection	Respiratory Infection	Eosinophil Count	Side Effects
1	7 weeks	10%	25%	—	—	—	—	6%	None
2	7 weeks	75%	75%	—	—	—	—	17%	Occasional Hypertension
3	5 weeks	75%	75%	—	—	—	—	14%	None
4	6 weeks	90%	75%	—	—	—	—	16%	None
5	5 weeks	75%	75%	—	—	—	—	12%	None
6	3 weeks	50%	75%	—	—	—	—	15%	Occasional Hypertension
7	6 weeks	25%	25%	—	—	—	—	8%	None
8	5 weeks	25%	25%	—	—	—	—	10%	None
9	3 years	10%	25%	10%	25%	75%	75%	8%	None
10	11 years	10%	10%	5%	5%	25%	25%	9%	None
11	11 years	0	0	0	0	0	0	6%	None
12	12 years	0	0	0	0	0	0	6%	None
13	6 years	25%	25%	10%	10%	50%	75%	12%	None
14	9 years	5%	10%	5%	10%	50%	50%	13%	None
15	10 years	0	10%	15%	10%	50%	75%	12%	None
16	9 years	5%	10%	5%	10%	75%	75%	12%	None
17	12 years	0	5%	0	0	75%	75%	9%	None
18	13 years	0	0	5%	0	75%	75%	10%	None
19	13 years	0	0	0	0	50%	50%	6%	None
20	16 years	0	0	0	0	25%	25%	8%	None
21	10 years	0	0	0	0	75%	25%	5%	None
22	16 years	0	0	0	0	50%	50%	6%	None
23	10 years	0	0	5%	5%	75%	75%	12%	None
24	11 years	0	0	5%	5%	75%	75%	11%	None
25	9 years	25%	50%	25%	50%	75%	75%	18%	None
26	4 years	5%	10%	0	5%	75%	75%	14%	None

Table 2. — Improvement Under Medication

Case	Age Medication Started	I. Q. When Medication Started	I. Q. and Age Rechecked After Medication Started		
			First	Second	Third
1	7 weeks	Moderate Mongoloid	72 (1 yr.)		
2	7 weeks	Moderate Mongoloid	110 (8 mos.)	105 (14 mos.)	98 (18 mos.)
3	5 weeks	Moderately Severe Mongoloid	94 (24 mos.)	92 (30 mos.)	
4	6 weeks	Slight Mongoloid	105 (6 mos.)	105 (9 mos.)	100 (12 mos.)
5	5 weeks	Moderately Severe Mongoloid	86 (4 mos.)	88 (8 mos.)	
6	3 weeks	Mild Mongoloid	78 (7 mos.)	80 (1 yr.)	
7	6 weeks	Severe Mongoloid	58 (5 mos.)	60 (10 mos.)	
8	5 days	Moderate Mongoloid	73 (4 mos.)	71 (13 mos.)	
9	3 years	24 3-22-55	26 (4 yrs.) 1-15-56		
10	11 years	30 1-19-52	34 (15 yrs.) 1-15-56		
11	11 years	28 1-19-52	30 (15 yrs.) 1-15-56		
12	12 years	32 1-19-52	30 (16 yrs.) 1-15-56		
13	6 years	38 1-19-52	38 (10 yrs.) 1-15-56		
14	9 years	33 1-19-52	28 (13 yrs.) 1-15-56		
15	10 years	35 1-19-52	32 (14 yrs.) 1-15-56		
16	9 years	33 1-19-52	35 (13 yrs.) 1-15-56		
17	12 years	18 1-19-52	22 (16 yrs.) 1-15-56		
18	13 years	30 1-19-52	31 (17 yrs.) 1-15-56		
19	13 years	18 1-19-52	16 (17 yrs.) 1-15-56		
20	16 years	22 1-19-52	20 (20 yrs.) 1-15-56		
21	10 years	24 1-19-52	22 (14 yrs.) 1-15-56		
22	16 years	30 1-19-52	31 (20 yrs.) 1-15-56		
23	10 years	29 1-19-52	25 (14 yrs.) 1-15-56		
24	11 years	25 1-19-52	20 (15 yrs.) 1-15-56		
25	9 years	35 1-19-52	66 (13 yrs.) 1-15-56		
26	4 years	40 4-5-55	40 (5 yrs.) 1-15-56		

the time of this report. He has not definitely decided as to progress made by this child.

A pediatrician of Orlando has been treating a child since approximately one month of age. In his opinion this child is making excellent progress, although more susceptible to respiratory infections than the average child. He believes this child has done much better than the untreated mongoloid child.

In Daytona Beach, another pediatrician has been treating a child since seven weeks of age. We have checked his I. Q. and found it to be in the neighborhood of 92. He is now two and one-half years old.

A pediatrician of Gainesville has treated a mongoloid from six days of age. At one month this child had much better muscle tone and was much more active than the average untreated mongoloid.

Discussion

Though the rationale for calf pituitary therapy has not been established, it is believed that the growth-stimulating factors should be much more prevalent in calf than pooled pituitary. We are not able to explain our results since the majority of endocrinologists are of the opinion that oral pituitary is destroyed in the stomach. There is a uniform eosinophil response in the differential counts while treatment is being administered. This suggests absorption of calf pituitary extract. Certainly further investigation in this field is warranted by our preliminary findings. The occurrence of three mongoloids with normal I. Q.'s and two others with low normal I. Q.'s might be explained by increased attention on the part of persons involved, but this would be unusual. Some increase in I. Q. may be explained by the increased physical activity of these children since much of the test results at this age depends on performance.

These results indicate that a need for further study of metabolic and endocrine function in these children is warranted. The types of mental and physical changes need further exploration. It may be that the avenue of investigation should be in studies of maternal metabolism and endocrine function during the prenatal period. Should this type of study prove productive it possibly would contribute toward eventual early detection of factors conducive to and prevention of mongolism.

Summary

Young calf pituitary, in a dosage of 1 grain daily increased at two week intervals until 4 grains is administered, has been given to mongoloids over a period of approximately two years, with varying results. In this series three patients have developed to within the normal I. Q. range, and some of the mongoloid stigmas have disappeared.

Clinical improvement observed in this preliminary study warrants continuation of this therapy and expansion of research along these lines.

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Florida Farm Colony.



Volume XLIV
Number 7

Syphilis in Shakespeare's Tragedies

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Between 1601 and 1609 Shakespeare published a series of tragedies in which mental illness or mental changes were an integral part of the plot and produced some of the tragic results. Hamlet, the introvert, feigned schizophrenia, while Ophelia's symptoms seem typical of that disease. In "King Lear" the old king suffered from senile dementia, while Edgar's portrayal of insanity was so realistic that one feels his gibberish, his hallucinations and his delusions could only have been gained from actual observation of such a case. Othello's pathologic suspiciousness brands him as a victim of a paranoid state, and in "Julius Caesar" are seen some of the results of the hero's epilepsy. Lady Macbeth's sleepwalking and amnesia suggest a hysterical state.

The last play in this series of tragedies is "Timon of Athens," in which an entirely different mental disease is portrayed. Timon is described in Shakespeare's play as a vigorous, healthy, cultured and influential man, a military leader, a dictator who is given the complete rule of Athens to deliver it from the enemy, a man in whom there then develops a severe dementia, a dementia which is rapid and characterized by symptoms typical of those occurring in paresis. In the development of Timon, Shakespeare has also brought in many signs and symptoms of syphilis, a disease prevalent in his time. Other plays in which symptoms or signs suggestive of syphilis are mentioned are: "Measure for Measure" (Act 1, Scene 2); "Troilus and Cressida" (Act II, Scene 3 and Act V, Scene 4); and "Henry the Fifth" (Act V, Scene I).

In analyzing "Timon of Athens" from the medical viewpoint one finds in the hero a clinical picture of paresis, an intriguing and curiously accurate picture. This Timon is not to be confused, however, with the original picture of Timon, a character clearly defined by Plutarch,[1] treated with much charm and with justice to his wrongs in a dialogue by Lucian,[2] a hero who from the personage of an obscure Athenian misanthrope of the fifth century B.C. became a traditional figure, a type or personification of misanthropy, adapted from Plutarch with only slight variations by a later writer,[3] and still later dramatized.[4] Then Shakespeare infused him with new life, with tragic intensity and profundity of feeling, surrounded him by the darkness of human greed and ingratitude, and adorned him with magnificence in passages of scorn and systematized delusions.

This picture one sees of paresis in Shakespeare's Timon has little to do with the obvious meaning of the tragedy, for no tragic hero is the victim of merely a disease. The heroic nature is vigorous in its nobility, with a single or few weaknesses, as the jealousy of Othello (which assumes paranoid proportions only under the pressure of villainy), and its fall, as Lear's madness, is brought about not by its own imperfection alone, but by spectacular external circumstances comprising the dramatic action. In short, the development of Timon's paresis is only a part of the tragedy of man with which Shakespeare concerns himself in his plays. The flaws in the nature of Timon he himself describes when he finds himself in debt after lavishing his wealth on his friends: "Unwisely, not ignobly, have I given."[5]

This fault, however, in itself is relatively unimportant. It disturbs Timon himself very little. The tragedy lies in its effect on his friends. The senators of Athens, whom he has protected and served with his money and military leadership, the other friends, who have crowded his house and repeatedly professed their devotion to him, will surely save him from poverty (a serious mistake indeed); but they do not. His friends prove false. Therein, in their nature, lies the tragedy. Such is the central theme of the play, essentially a portrayal of human baseness, the parasitic nature of man and the perfidy of false friends, their effect upon a character both generous and ingenuous—a theme set forth in the first, the introductory scene:

> When Fortune in her shift and change of mood
> Spurns down her late beloved, all his dependants
> Which labor'd after him to the mountain's top

Read before the Regional Meeting of the American College of Physicians, Charleston, S. C., Oct. 8, 1955.

Even on their knees and hands, let him slip down,
Not one accompanying his declining foot.

'Tis common: . . .[6]

In his affluence, while he gave unwisely, himself a model of the friend in need, Timon with naive faith in friendship, part and parcel of his excessive generosity, attributed to all men his own virtue, though the bitter wisdom of the surly, cynic Apemantus sounded a continual refrain of warning in his ear. When, with one excuse and another, the former recipients of his bounty, his former companions, refuse to help him:

They have all been touch'd and found base metal, for
They have all denied him.[7]

Their evil so outweighs the good of his loyal steward as to obliterate it and to nullify its effect, just as the evil daughters of Lear overpower their one good sister. In his great disillusionment Timon rejects that "One honest man."[8] The shock of this disillusion, the impact of ingratitude on his too generous and confiding spirit, effects a transformation, even as the cruelty of filial ingratitude ruins the too generous and confiding Lear. From extreme magnanimity, indiscreet, indiscriminate charity, all-embracing good will, he is then thrust by the worthlessness of his friends, the chief citizens of the city, into a state of extreme, all-inclusive misanthropy, terminating in the defeat of Athens by the banished Alcibiades, whom he assists as a means of revenge, and ending in his own death. That he loses judgment and experiences paranoid delusions does not detract from the main fact of the evil of man's ingratitude, but serves better to emphasize man's disregard and exploitation of weakness and sickness.

This theme of predominant evil—though the play, because of its uneven quality, its frequently poor rhythm and imagery, and its inferior action, is usually assumed by literary critics to have been written in part by a less gifted playwright—is in accord with Shakespeare's consistent despair. This lusty, clear-sighted despair is echoed throughout his tragedies, as in the welcome to Lear's death, a relief that the old king be stretched out no longer on the rack of the world, or in Hamlet's soliloquy of frustration. In Timon this theme of predominant evil is continuous and it is integrated by the fact of Timon's progressive dementia so that the play must have been written as a continuous process, one in which one sees the continuous clinical picture of syphilitic encephalitis.

Turning now to consideration of the clinical picture, one focuses attention on quite a different aspect of the many-sided playwright. Even a casual study of the plays reveals his remarkable knowledge of subjects medical and surgical, of the symptoms and progress of physical disease, even of psychopathology—an aspect of his universality of characterization, his penetrating and comprehensive portrayal of the human scene, most interesting and significant to physicians. Numerous passages demonstrating this knowledge have been collected from his plays by Wainwright[9] and subdivided into the various medical branches which they seem to illustrate. Certain characters alone, such as Lear in his madness and the distracted Ophelia, appear to be prototypes of the afflicted.

Whether Shakespeare understood in the academic sense all the medical data that he used, or whether he borrowed his information from sources at hand—the heterogeneous mass of literature from which he derived material, or the physicians themselves with whom he was acquainted[10]—it is evident that he knew the facts of disease as they influence human behavior. With astounding insight, he even evokes psychotherapy:

Canst thou not minister to a mind diseased,
Pluck from the memory a rooted sorrow,
Raze out the written troubles of the brain,
And, with some sweet oblivious antidote
Cleanse the stuff'd bosom of that perilous stuff,
Which weighs upon the heart?[11]

The frequency of his mention of medical matters provides ample proof that much of the medical lore and superstition of his day was familiar to him. In "The Tempest" an acquaintance with tuberculosis is suggested: "As if it had lungs and rotten ones."[12] Lines in "Julius Caesar," printed in 1623 in the same folio with "Timon of Athens," describe the circulation of the blood back to the heart[13]—a most recent discovery, for Harvey's views on the movements of the heart and blood were first made public in his course of lectures begun in 1616 at the Royal College of Physicians in London, though his "Exercitatio anatomica de motu cordis et sanguinis" was not published until 1628.

References to the manifestations of syphilis are numerous, attesting its prevalence in Shakespeare's time. About 1500 or earlier, it had appeared as a new disease or a highly active form of an old one. Whether or not it had been brought back from the West Indies by Spanish sailors with Columbus is beside the point. It spread from Italy, where the soldiers of Charles VIII of France carried it to Naples, then throughout Europe, so widely that one observer wrote: "It

involved the Pope on his throne to the humblest workman."[14] Following the first description by Leonicenus[15] and a description by Astrock, it became more and more a subject of general discussion. About 1530 Fracastorius, an Italian physician, published his poetic description of the symptoms in a shepherd called "Syphilus," whence the disease takes its name. By 1600 it had become still more widespread, pursuing the course of unusual severity characteristic of an infectious disease occurring among a people unprotected by any previous infection with it. It is, therefore, not difficult to assume that Shakespeare may have known personally people in whom paretic dementia developed. This type of insanity, in the light of purely medical analysis, a narrowly specialized examination of the subject, seems reflected in this character, Timon.

While fully discounting the flamboyance of Elizabethan diction and the necessity for overemphasis in the drama, one discerns in Timon's extravagant generosity, fantastic, pathologic elements:

> He pours it out . . .
> No meed, but he repays
> Sevenfold above itself; no gift to him,
> But breeds the giver a return exceeding
> All use of quittance.[16]

He imagines the pleasure of lavishing even more:

> Methinks, I could deal kingdoms to my friends,
> And ne'er be weary.[17]

while his steward complains:

> He commands us to provide, and give great gifts,
> And all out of an empty coffer: . . .
> His promises fly so beyond his state
> That what he speaks is all in debt; . . .[18]

and Apemantus comments:

> O you gods, what a number of men eat Timon, and he sees 'em not! It grieves me to see so many dip their meat in one man's blood; and all the madness is, he cheers them up too.[19]

Grandiose ideas, a failure to grasp reality, a pronounced exaltation—symptoms typical of paresis, not the simple dementing type but the grandiose form—are clearly apparent. To one familiar with the usual case of this form of syphilitic encephalitis, the picture of progressive paretic dementia, seemingly condensed here for purposes of the drama, is amazing in its accuracy.

As if the syphilitic spirochete, Treponema pallidum, were indeed destroying his brain cells, Timon further furnishes abundant evidence of mental deterioration, so strongly suggestive are his actions. He speaks of friendship with what might be called all the maudlin sentimentality of an enfeebled mind and an almost paranoid self satisfaction. His words, his views, so frequently childish, are scarcely credible in a man of his years and experience unless one bears in mind the fact that it is usually in middle age that paresis manifests itself. Oblivious, blind to the most obvious frauds, divorced from reality,

> There is no crossing him in 's humor . . .[20]

He neglects his affairs, and refuses to believe his steward when informed of his dwindling fortune.

> No care, no stop! so senseless of expense,
> That he will neither know how to maintain it,
> Nor cease his flow of riot: takes no account
> How things go from him, nor resumes no care
> Of what is to continue . . .[21]

These warnings of Flavius fall on deaf ears. What is evident to others Timon cannot see, his own condition least of all—a lack of insight notorious in one who suffers from grandiose paresis.

Equally symptomatic, as the drama develops, are his emotional instability and lack of self restraint. At the mock banquet (of water) to which he invites his former friends, he showers on them furious abuse, and the water and dishes as well. He disintegrates rapidly, giving way to wild rage and violence. In his failure to recognize his steward, one perceives his loss of memory. In the coarseness of his speech—a coarseness not extreme by the liberal Elizabethan standards, but far out of keeping with his customary gentleness as an aristocrat—one finds further disintegration. Sadistically, he rails at the courtesans of Alcibiades:

> This fell whore of thine
> Hath in her more destruction than thy sword,
> For all her cherubin look . . .[22]

> Be a whore still: they love thee not that use thee;
> Give them diseases, leaving with thee their lust.
> Make use of thy salt hours: season the slaves
> For tubs and baths; bring down rose-cheeked youth
> To the tub-fast and the diet.[23]

Timon further waxes incoherently eloquent:

> Matrons, turn incontinent!
> or
> . . . to general filths
> Convert o' the instant, green virginity
> or
> Maid, to thy master's bed;
> or
> Son of sixteen,
> Pluck the lined crutch from thy old limping sire,
> With it beat out his brains!
> or
> Lust and liberty
> Creep in the minds and marrow
> of our youth . .
> or
> Itches, blains,
> Sow all the Athenian bosoms; and their crop
> Be general leprosy![24]

He talks insanely, yet he values himself highly:

> But myself,
> Who had the world as my confectionary,
> The mouths, the tongues, the eyes and the hearts of men
> At duty, more than I could frame employment, . . .[25]

After such outbursts he is repeatedly labeled by those who observe him as a madman, until "full of decay and failing"[26] he succumbs to sudden death.

Not only are the findings here ample for a diagnosis of paresis, but the most violent dramatic form of the disease is here uncannily though, without a doubt, unintentionally pictured. Certainly, paresis as a clinical entity was not described in the time of Shakespeare. That the presence of the disease paresis is superfluous to the tragedy as a whole can be admitted, particularly when one reads some of the passages describing syphilitic symptoms which actually have no effect on the over-all plot, such as:

> Consumptions sow
> In hollow bones of man; strike their sharp shins,
> And mar men's spurring. Crack the lawyer's voice,
> That he may never more false title plead,
> Nor sound his quillets shrilly; hoar the flamen,
> That scolds against the quality of flesh,
> And not believes himself: down with the nose,
> Down with it flat; take the bridge quite away. . .[27]

or

> . . . make curl'd-pate ruffians bald;
> And let the unscarr'd braggarts of the war
> Derive some pain from you: plague all;
> That your activity may defeat and quell
> The source of all erection.[28]

Actually, for the purposes of the play, Timon as a clearcut character of an overly generous man whose wits are "drowned and lost in his calamities"[29] would suffice. The fact, however, of his having been described as a victim of paranoid dementia at the same time that many overtones of syphilis are thrown into the description can only suggest that Shakespeare thought that the disintegration of the hero would be much more striking and much more calamitous by this addition of the paretic state, thus giving Wainwright the argument that the whole play was written by Shakespeare, not by lesser playwrights in the last three acts, as many critics have insisted. Shakespeare must have observed persons once, or perhaps several times, with symptoms of paresis and in his creation of the character of Timon blended his observations. The resemblance is so striking that were a skillful actor to simulate in the part certain physical manifestations of the disease—tremors and speech defects—the picture would certainly be complete.

One can assume, for the sake of argument, that Shakespeare recognized that certain syphilitic processes lead to a type of insanity which is now called paresis, and this argument, of course, is well documented by the descriptions and the speeches of Timon. Nevertheless, it is equally arguable that Shakespeare merely used symptoms of syphilis and paresis to emphasize the destruction of a personality by the overwhelming evil of the world and men, a necessary attribute for the heroic state in the play. If, however, one keeps in mind the protean nature of the disease, paretic dementia, the uncanny ability of Shakespeare to describe medical subjects, and his great interest in mental disease, the play "Timon of Athens" becomes, not a partial work of Shakespeare, not a lesser play, but a classic, a source book for students of the history of syphilis.

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24. Act IV, Scene 1, lines 3, 6-7, 12, 13-15, 25-26 and 28-30.
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27. Act IV, Scene 3, lines 151-158
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Number 7

Office Study of the Infertility Problem

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One portion of the general field of gynecology that has shown great progress during the past two decades is that of the study and treatment of the relatively sterile, or infertile woman. So much attention has been accorded this problem that the care of the infertile couple has become almost a subspecialty of its own. Such specialization should not deter the practicing gynecologist from engaging in this type of work; nor, in communities where no gynecologist practices, deter the general practitioner from helping infertile couples. Although these patients are not ill, they number among their group the most appreciative of all patients; and many complaints of a psychosomatic nature are assuaged, or indeed dissolved by the happy occurrence of a successful conception.

At the same time, it behooves the physician who assumes the study of one of these problems to devote to it a sufficient amount of time as well as training. In few other instances is an insufficient amount of attention more harmful, as a half-performed study may often lead to early discouragement, and the failure later to seek more complete assistance at competent hands for this complaint. If adequate physician time or interest for a complete work-up is not available, the patient is best served by referral to that physician who owns these equally precious qualities in addition to the necessary training.

Many plans and procedures have been advocated for the study of the infertile woman. The plan proposed here combines the advantages of thoroughness with the attributes of systematic ease and relative inexpense. Throughout this paper I have avoided any discussion of the treatment of the infertility problem, this being in itself an equally large field of endeavor, although dependent throughout upon the results of the diagnostic study.

The proposed infertility study is arranged over a course of five office visits, four visits following the original consultation and statement of the problem. The patient is allowed the opportunity to become pregnant throughout most of the study, which happy circumstance would make the later visits totally unnecessary.

Initial Consultation

At the time of the first visit a complete history is taken, with especial interest as regards illnesses, injuries, or operations. A complete physical examination is also performed, with interest centering in constitutional deficiencies which would possibly affect fertility. Elaboration on this point is not necessary.

A careful pelvic examination is included, and any deviation from normal pelvic development and anatomy is noted. The cervix is especially regarded from standpoints of position, stenosis, and inflammation. The cervix is sounded if the uterus is firm and small and the last menses within the preceding two weeks; otherwise, this procedure is left to a subsequent visit.

The patient is returned to the consultation room, and the results of the examination are explained, with particular emphasis on normalcy when present, but equal recognition of poor prognostic findings. If the condition of absolute sterility has been uncovered, the study ceases. If a correctable pelvic pathologic condition exists, this is attended to before continuance.

Following reassurance to the patient that the necessary anatomy is present and apparently normal, the physiology of reproduction is outlined and the further study thereof explained. The cost of the visits is discussed frankly. If the patient desires to undergo the remainder of the study, she is given a basal temperature chart with instructions to keep this from the viewpoint of a factual reporter only, to bring it with her on each subsequent visit, and to attempt to draw no conclusions of any kind from this chart. She is further instructed to telephone the office on the first day of her next menses, at which time she is given an appointment for the fourteenth day of her cycle, or the fourteenth day premenstrual to the following expected menses. If she should skip her next menses, she is told to arrange an examination three weeks later for a possible diagnosis of early pregnancy.

If the patient does not wish to undergo the proposed study, the consultation is regarded as a routine examination. The patient is advised to

return for routine check-up examinations, and during the interim between visits both physician and patient hope for a spontaneous solution to her problem. It might be added that for some reason, possibly a psychosomatic one rather than a purely statistical one, pregancy follows no study or treatment other than the original consultation.

Second Visit, Cervical Mucus Evaluation

At the second visit, the patient is placed on the examining table, having been instructed when she called to make the appointment to have had intercourse within six hours, and preferably two hours, before her office appointment. There should be no precoital or postcoital douche and no medication or contraception. A bivalve speculum is introduced, and the cervix wiped dry with a clean cotton ball without medication. A smooth thumb forceps is introduced into the external os, and cervical mucus is obtained by a twisting motion, placed on a slide, and examined immediately under the microscope. The patient is kept on the table in case of a poor specimen, when a second specimen is taken, or for a recheck pelvic examination to confirm that of the initial visit. At this time the cervix is sounded. She is then returned to the consultation room.

If the specimen shows 20 to 50 active sperm per field, it is assumed that the husband is contributing his share, and that the technic of coitus is satisfactory. If the cervical mucus is below par, the husband is referred to a urologist for infertility study, and there is further investigation into the coital technic employed, which otherwise is only touched upon. Further work-up awaits the report of the urologist in this event.

Assuming a good specimen, the patient is reassured, any questions raised by the foregoing work-up are answered, and the basal temperature chart is examined. The patient is instructed to call with the next menses, at which time appointment will be given for the twelfth day of the cycle, or the sixteenth premenstrual day.

Third Visit, Rubin Test

The patient makes the third visit on the sixteenth day preceding her expected menses, following at least four days of abstinence from intercourse. Pelvic examination is performed following examination of the basal temperature chart, the physician being careful to note the size and the position of the fundus. The Rubin test is then performed in the usual manner with carbon dioxide gas, confirming the visual positive result on the gauge by auscultation and the shoulder pain sign.

If the result is a negative one, the procedure of the third visit is repeated. With a second negative result, roentgen investigation by means of hysterosalpingography is recommended.

If the result is positive, the patient is advised that the optimum time for intercourse now exists, and that there should be coitus on the next three or four nights, or more if possible. There should be an interval of another month without further investigation if pregnancy does not ensue. The month following, the patient should abstain from marital relations, and an endometrial biopsy should be scheduled for two to three days before the next expected menses. If there is reason in the individual case to hesitate losing even this one month from exposure to pregnancy, the biopsy can be scheduled for the first day of menstrual flow in either of the succeeding months.

Fourth Visit, Endometrial Biopsy

At the time of the fourth visit, the patient is prepared for examination while the basal temperature chart is reviewed. Endometrial biopsy is performed, with or without an accompanying vaginal smear. With the Novak curet, this is no more of a procedure than the Rubin test. This is also a good time to perform a cautery of the cervix, if indicated. The patient is given an appointment to return following her next menses unless cautery has been performed, in which event the appointment is made for three weeks following.

Fifth Visit, Summarization Consultation

At the fifth visit, the patient has a general summarization of the results of the entire investigation explained to her. There is an attempt made to give her a fertility quotient. The weak points in her fertility makeup are discussed at some length, and the treatment program outlined. In a small number of cases the results of study to this point will have pointed in the direction of one unusual or a combination of unusual factors which dictate specialized and advanced study. This is on the borderline of therapy in itself, and beyond the scope of the present discussion.

Summary

A simplified method of the office study of the infertile woman is presented that is adaptable to the average private practice of gynecology. The entire study outline as well as a simplifed explanation of the physiology of reproduction is presented to the patient at the initial visit, in order that

she may understand exactly what is entailed. It is explained that the entire study must be performed, since often there is a combination of factors present to account for the infertility. Naturally, conception may occur at any time throughout the progress of the study, and the remainder precluded. No attempt is made to elaborate on the deviations from the basic study pattern occasionally indicated, nor to discuss the therapeutic aspects of this subject, an equally large topic in its own right. It should be emphasized that a thorough understanding of the entire subject be transmitted to the patient in order to obtain complete cooperation on her part and the full benefits of the psychosomatic component.

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Labor With Emphasis on Stage I

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MOUNT DORA

The advent of new agents for stimulating labor makes it necessary for the physician to re-evaluate its management. More and more it is becoming the fashion to induce labor in the expectant mother as she approaches term or to stimulate the "sluggish" labor or primary inertia. These procedures carry with them certain dangers.

This article probably could more appropriately be said to deal with the conduct of the physician during labor rather than the "conduction" of labor. Its purpose is to stress primarily stage I, that portion of labor that all too frequently the physician fails to observe. He leaves the patient in the care of the nurses, orders medication over the telephone and makes his appearance at the more active and stimulating phase of labor, stage II. During stage I the course of stages II and III is plotted, and it is here that the final outcome of the pregnancy usually can be determined.

The onset of stage I is signified by uterine contractions occurring at regular intervals. These may commence spontaneously or be induced.

The spontaneous onset of stage I may be either of good quality, consisting of strong contractions occurring at eight minute intervals, then dropping to five minute and three minute intervals, lasting at least 40 seconds with progressive effacement and dilatation of the cervix, or it may be sluggish with short contractions 30 seconds or less in duration occurring at irregular intervals varying in length from 15 minutes to three minutes. There is no progress in the effacement or dilatation of the cervix. Fundal dominance is absent.[1]

In the "sluggish" or hypotonic type of labor, much can be done to help shorten the time the expectant mother spends in stage I. Often a minim of Pitocin given subcutaneously is sufficient to cause the uterus to enter into a labor of good quality with contractions occurring at three minute intervals and lasting 40 seconds or longer. The contractions obtained are frequently extremely hard, near tetanic in character; they relegate the method to selected cases which should be in multiparas with a well effaced, "ripened" cervix dilated 4 cm. with the vertex well down in the pelvis and the membranes already ruptured.

Method of Administering Oxytocics

Giving Pitocin or oxytocics subcutaneously or intramuscularly in this stage carries with it dangers which can be circumvented by giving the substance intravenously. One is not able to control the patient's "pick-up" of the medication from the site of the injections; therefore, the desired effect may not be obtained.

The most satisfactory and safest method that the physician may use to aid and stimulate the progress of labor at this stage is the administration of Pitocin intravenously.[2] This also applies to other medications which are given, such as Demerol and scopolamine. The response is more readily controlled when the drug is given intravenously. A 1:5,000 solution of Pitocin is preferable to the 1:1,000 solution, for I have found that the control of the more dilute solution is easier at the onset and up to 40 minims per minute may be given.[3] With a stronger solution no more than 8 minims per minute should be given.

Regardless of the method used, the physician who is responsible for the course of the labor should be with the patient. During the first 30 minutes of induction he should have one hand on the abdomen and the other ready to stop the Pitocin if the contractions become too strong.

This procedure should be carried out for at least the first 30 minutes. The patient should be followed closely by the physician throughout the period that she is receiving the Pitocin. Unless the physician is attending the patient continuously, adequate control is not obtained, and accidents may result.

Prior to giving Pitocin by either of these methods, it is wise to carry out a few simple procedures: 1. Wipe the membranes away from the cervix. 2. Rupture, if possible, the membranes. Often this is enough to stimulate the "sluggish uterus" into an active procedure. Occasionally, there is no fluid between the oncoming head and the membranes, or the cervix may be posterior, which makes rupture of the membranes difficult. In such cases, merely wiping the membranes will usually suffice. This, of course, requires the physician to be standing by and managing the case rather than the nurse assigned to the labor room.

Induction of Labor

The physician who embarks upon an induction of labor should well consider the state of the patient and fetus prior to induction. The patient's emotional status as well as physical condition must be considered. If certain criteria are fulfilled, the induction can be undertaken fairly safely. If not, then one is assuming the responsibility of added risks against a satisfactory outcome.

The requirements that are necessary for induction of labor are a vertex presentation at mid pelvis with a well effaced cervix dilated 2 to 4 cm. and with the membranes either stripped from the cervix or ruptured. If the membranes are not already ruptured, then they should be manually ruptured as soon as possible. Labor should then terminate in six to eight hours.

Here again a 1:5,000 dilution of Pitocin is preferred because of the ease with which it can be controlled. The physician should be with the patient throughout the first portion of the induction, one hand resting on the abdomen to feel the uterine activity and the other used to control the flow of Pitocin, gradually increasing it as is indicated to him through his hand on the uterus. Contractions should be approximately 45 seconds in duration at three minute intervals.

Too rapid a flow of Pitocin may produce one or more of the following conditions: uterine tetanic contractions; rupture of the uterus; laceration of the cervix, vagina and perineum; or fetal damage.

It is advisable to use a Y tube with a bottle of 5 per cent dextrose in water in tandem with the Pitocin solution. This setup allows fluids to be given to keep the vein open if the Pitocin is temporarily discontinued.

If tetanic contractions or Bandl's ring occurs, the Pitocin should be stopped. Deep anesthesia with ether will often cause the uterus to relax. Ether requires 10 to 30 minutes to give, depending upon the previous medication that the patient has received. Magnesium sulfate, 1 Gm. in 20 cc. of diluent, given intravenously is a much easier method.[4] Often amyl nitrite, when inhaled, will relax the contracting ring.

With rupture of the uterus, rapid surgical intervention is indicated. Lacerations of the cervix, vagina or perineum are usually not detected until after the end of stage II or III. These, of course, are repaired. The damage to the infant may be apparent early or may not be detectable until long after the delivery.

It is important to remember that the use of Pitocin brings increased responsibility for the physician who desires to use it in his armamentarium. Pitocin is a powerful agent and should be handled with respect. It should not be used with a laissez-faire attitude. Above all, the patient should be under the constant supervision of the physician.

Summary

This article deals principally with the conduct of labor during stage I.

Emphasis is placed upon the physician's responsibilities during this stage of labor with special emphasis on the proper use of Pitocin.

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Clinic Building.

ABSTRACTS

Traumatic Torsion of the Lung. By DeWitt C. Daughtry, M.D. New England J. Med. 256:385-388 (Feb. 28) 1957.

Torsion of the lung is a rare complication of thoracic trauma. Its diagnosis should be suggested by crushing or compression injury of the lower thorax associated with the early x-ray finding of a vascular pattern that radiates superiorly and laterally, with rapid disappearance of breath sounds and prompt progression to a homogeneous density of a ground-glass type.

A case of traumatic torsion of the lung in a seven year old girl is reported in which the patient survived after extensive surgery and is in excellent condition. The one remaining segment of the left lung occupies most of the left side of the thorax and is apparently serving a useful purpose. There is some experimental and clinical evidence that lung growth takes place in a child seven years of age. Serial pulmonary function studies will appear in a subsequent report. The only other reported case terminated fatally. Early recognition of what seems to be a diagnostic x-ray sign should alert one to proceed with operation before irreversible pulmonary changes have occurred.

In addition to the salient features of diagnosis, the pertinent differential diagnoses are discussed. A theory of the mechanism of torsion of the lung is proposed.

Removal of Urethral Calculi by Johnson Stone Basket. By Raymond J. Fitzpatrick. J. Urol. 77:377-381 (March) 1957.

A simple method for the removal of impacted or obstructing urethral calculi under 2 cm. in diameter is proposed. Three cases are presented in which calculi impacted in the urethra were readily extracted at the office by means of a Johnson stone basket attached to a 33 cm. woven urethral filiform (No. 56 thread). A finger should be inserted into the rectum for stones in the prostatic urethra, or the stone should be grasped between the thumb and index finger when located in the more accessible portions of the urethra, as simultaneous basket manipulation with the opposite hand is accomplished. The procedure may be performed under topical anesthesia with or without trilene analgesia. The size of the stone and the existence of an urethral caliber estimated to be adequate for its passage should be known before one attempts to ensnare and extract it. Calibration should extend down to the stone but not beyond it for fear of possibly pushing the calculus back into the bladder. For calculi greater than 1.0 cm. in diameter, it is suggested that the capacity of the basket cage be increased by outward bending of its wires. Whether meatotomy, urethrotomy or endoscopy is indicated depends upon each individual case.

After the preparation of this paper, five of several calculi found on routine urethral calibration, none of which was obstructing the urethra, were readily removed by this method from the prostatic urethra of a patient awaiting admission to the hospital for urologic surgery. The largest of the stones was 1.2 cm. in diameter.

Segmental Liver Revascularization. AN EXPERIMENTAL STUDY. By H. Clinton Davis, M.D., and Irwin S. Morse, M.D. A. M. A. Arch. Surg. 74:525-527 (April) 1957.

Since Vineberg's observation that implantation of the internal mammary artery into the myocardium will result in collateral circulation had not been experimentally applied to other organs, this study was undertaken for investigative purposes in the hope that it might lead to a method of segmental arterialization of the liver in which both a revascularized lobe and control lobes could be evaluated in the same animal. The method employed and the results obtained are described. It is concluded that direct implantation of the splenic artery into a normal canine liver lobe can result in endothelial proliferation and collateral circulation with hepatic vessels. From a quantitative standpoint the amount of collateral anastomoses created by this technic in normal liver tissue is not impressive.

Experiences in Intravenous Urography Using Hypaque. By Benedict R. Harrow, M.D. Am. J. Roentgenol. 75:870-876 (May) 1956.

A new urographic agent, containing 59.9 per cent iodine with 3 iodine atoms per molecule, was introduced in 1954 under the name of Hypaque. In the study reported here, this medium, supplied as a 50 per cent solution, was used in a series of 50 patients, half receiving 30 cc. and

half receiving 60 cc. It was concluded that this agent was an excellent, almost ideal, urographic substance with minimal side reactions, and yet with roentgenographic densities equal to urokon, when equivalent molecular loads are utilized. No pain in the arm occurred with slow injections. No proteinuria or crystalluria resulted even after the 60 cc. dosage.

The urine concentration of all organic iodides is limited to a 0.2 molar concentration no matter how great the molecular load. Hypaque results in a decreased hydrogen ion concentration of the urine in contrast to other organic iodides, perhaps because of the inhibition of renal carbonic anhydrase. Some of the osmotic relationships in excretion are discussed.

The most important factor in obtaining excellent urograms, the author observes, is the proper use of adequate compression for two minutes. Most technicians do not understand the factors involved so that poor filling is obtained, leading in most hospitals to discontinuance of this valuable procedure. The physician in charge must take an active interest in teaching the correct intravenous pyelographic procedure to technicians.

The Clinical Problem of Adiposity of the Heart and Cardiac Enlargement of Undetermined Etiology. By H. J. Roberts, M.D., F.C.C.P. Dis. of Chest 31:84-92 (Jan.) 1957.

In this report, the problem of fatty infiltration of the heart is discussed, and a probable case of adiposity of the heart diagnosed clinically in a living 30 year old man is presented. The patient's asymptomatic cardiomegaly decreased radiographically but slightly after six months, even with decided reduction in weight. The author observes that this entity, which to his knowledge has heretofore been only a postmortem diagnosis, should be suspected in patients demonstrating unexplained cardiomegaly in the presence of a recent rapid and profound gain in weight and in the absence of the stigmata of the other causes of heart disease. The condition may be either asymptomatic or manifested by heart block and congestive heart failure.

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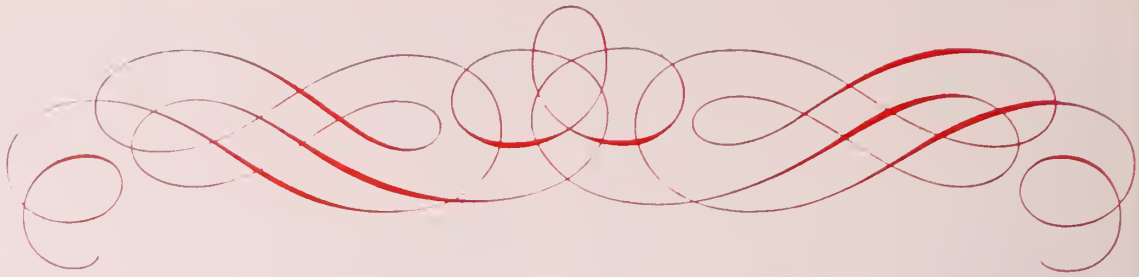
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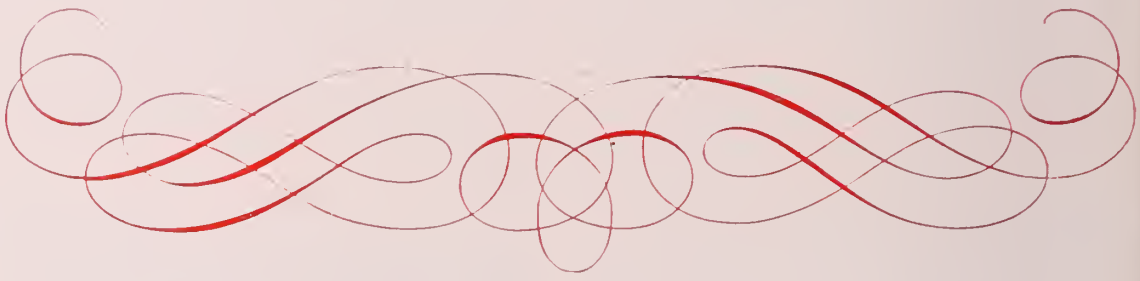
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THOUGHT FOR A

NEW YEAR



YESTERDAY

is but a Dream, and To-morrow is only a Vision, but To-day well lived makes every

YESTERDAY

a Dream of Happiness, and every To-morrow a Vision of Hope. Look well, therefore, to This Day!

THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION
OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. Box 2411 Jacksonville, Florida

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A Trend Toward Less Hospitalization?

Until the late nineteenth century, the hospital was generally viewed as a pest house or as a suitable place for the confinement of patients in the terminal stage of illness. Surgical and nursing technics were of such a nature as to discourage rather than encourage the use of the hospital. In the past 75 years, however, this picture has changed completely. Improved technics have made the hospital a "safe" place, and Blue Cross and other insurance plans have helped to fill our hospitals to overflowing. This trend toward acceptability has become so general, in fact, that the number of hospital beds per 1,000 population has become one of the indices of a community's health — or, at least, of its concern for health.

There are beginning signs, however, that such an index may become less reliable in the future. Two examples — both within Florida — will suffice to illustrate this fact. Several decades intervened between the time when tuberculosis was seen to be a major health problem and that when the provision of an adequate number of specialized hospital beds for tuberculous patients was thought to be economically possible. The first state hospital for the treatment of tuberculosis in Florida was opened 20 years ago; almost 15 additional years were required before the goal of a complete state system of such hospitals was achieved. (Few States, incidentally, have made comparable progress in this area.) Even before the last of these hospitals was opened, however, the picture was changing. Better medical care, improved economic conditions, more adequate case finding methods, more diligent search for infected persons, and a more general knowledge of health and illness — all of these contributed to a decided decline in death rates from tuberculosis.

Almost coincident with the completion of the tuberculosis hospital system was the availability of new drugs to shorten the period of necessary hospitalization and to make home care and treatment medically, economically and socially feasible. Disagreement still exists as to the length of time the person with tuberculosis should remain in the hospital, but the fact remains that in Florida, as elsewhere, there is less need for hospital beds for this disease, and that the hospital censuses are declining. For tuberculosis, at least, we have arrived at a point where the number of beds devoted to patients with this

disease is neither an adequate index of the relative freedom from the disease nor of the efficiency of measures being undertaken as treatment.

A comparable development in the area of mental disease is apparently in its initial stages. The feverish building of facilities for care of the mentally ill has been the recent answer to our self castigation for the past neglect; the ratio of psychiatric beds to population has become an important index in measuring both sensitivity to the problem of mental illness and the extent of treatment. As in the case of tuberculosis, however, new concepts of treatment and new therapies have now appeared; these give more than casual promise of decreasing the hospital stay of many psychiatric patients, and of shifting the site of treatment to the psychiatrist's or even the general practitioner's office and to the patient's home.

Nor should we think only in terms of special purpose hospitals in this connection. In the case of general hospitals similar factors have been at work. Modern medical technology has reduced radically the average stay of a patient, and many persons are now treated in the physician's office who formerly would have required hospitalization.

The need for additional hospital beds is not a spurious one, however. The dramatic increase in population, improved economic conditions and insurance coverage of hospital care have together greatly increased the demand for hospital beds. The alertness to need and demand for more medical care on the part of the general public is real. What, then, is the challenge to the medical profession?

Fortunately, the physician is by education, training and experience able to adapt himself to the changes occurring in the practice of medicine. If he views medical care in its largest perspective, the modern physician is able to emphasize preventive measures, to use his office as a treatment center, and thus to continue many patients in their job, home and community relationships. With the new technics at hand, the physician is less rather than more dependent upon the hospital; with such, the patient is less subject to the economic, psychologic and social distortions of life for himself and his family which are so often caused by hospitalization, and the latter, obviously, is an important goal of the modern physician.

If, therefore, the trend toward less need for hospital beds is real, it is a healthy one, and every physician should use his best efforts to promote it.

Advance Planning for Annual Meetings of Specialty Groups

Specialty groups approved by the Florida Medical Association which regularly hold meetings at the time of the Association's Annual Meeting are being requested to schedule their sessions this year on May 10, Saturday morning, afternoon and evening, and May 11, Sunday morning and evening. These dates have been reserved for the meetings of specialty groups by the Board of Governors of the Association and are identical with arrangements followed last year at the convention in Hollywood.

The dates for the Association's Eighty-Fourth Annual Meeting are May 10 to 14, and the place is the Hotel Americana, Bal Harbour, just north of Miami Beach. The first session of the House of Delegates convenes on Sunday afternoon, and the Board of Governors has ruled that no conflicting meetings are to be scheduled. All specialty societies, therefore, are urged to conclude their programs before this time, or recess until the meeting of the House of Delegates is finished.

Letters requesting certain information about the meetings of specialty societies have been sent to the secretaries of the various societies by the Association's executive office. The secretary of each group is requested to give the number and time of the sessions scheduled and also information about luncheons, dinners and other social activities.

It is expected that some societies may desire to combine meetings because of the importance of a speaker or the overlapping of his subject into the field of a closely allied specialty. Arrangements should be worked out between the specialty groups involved before the information is sent to the Florida Medical Association. The problem of closely related societies meeting at the same time has been a source of annoyance to many physicians. Each society may have an outstanding program which would attract a sizable audience if the meetings were combined. When the meetings conflict, the physician feels his duty is to his own specialty group and therefore may have to forego hearing an outstanding speaker whom he desired to hear.

The programs of the meetings of the specialty groups are scheduled for publication in the April issue of The Journal along with the program of the Annual Meeting of the Association. Specialty group program chairmen or other officers in charge of the program are urged to begin compiling their program as soon as possible in order that a copy may be sent to The Journal on or before March 1, the deadline for copy for the April issue.

The importance of the completeness of the program cannot be overemphasized. Speakers should be identified by title and city. The titles of all addresses should be given. If there is to be an afternoon and an evening session, this schedule should be made clear in the program. Cocktail parties and dinners should be planned in advance and made a part of the program. If a speaker has been scheduled for the dinner session, he should be identified and the title of his address given. Basic planning would assure adequate accommodations for the social affairs, adding to the enjoyment of members of the specialty group as well as guests.

Physicians in charge of arrangements for alumni and fraternity functions to be held at the time of the Association's Annual Meeting should provide information about these affairs to the Association's executive office. The date, time and number of persons expected are important.

"What Is An Ophthalmologist?"

A notorious example of public confusion in the field of medical care pertains to the difference in the training and functions of ophthalmologists, opticians and optometrists. Recently, the National Medical Foundation for Eye Care was established by American ophthalmology to create a better public understanding of the professional and scientific standards of good eye care, and of the qualifications and functions of ophthalmologists and all the related technical personnel who assist them in providing eye care to the public. The Foundation gathers, studies and disseminates information to the medical profession and the public alike relating to scientific eye care.

A leaflet entitled "What Is An Ophthalmologist?" has now been published by the Foundation, defining an ophthalmologist, an optician and an optometrist. It is being widely distributed by ophthalmologists to their patients and should be quite as interesting and useful to other members of the medical profession as to ophthalmologists. It is available on request to the Foundation, which has executive offices at 250 West Fifty-Seventh Street, New York 19, New York. The definitions are as follows:

An Ophthalmologist is a physician—a doctor of medicine—who specializes in the care of the eye and all the related structures. He diagnoses and treats defects of focus, disorders of function, and all other diseases of the eye, prescribing whatever is required, including glasses. He is often concerned, as a consultant member of the medical team, with diseases of other systems of the body or general diseases which manifest themselves in the eyes—diabetes, toxemia of pregnancy, cancer, multiple sclerosis; tuberculosis and other infections, hypertension, muscular dystrophy and heart disease, among others. Ophthalmology is a branch of medicine and the ophthalmologist is an eye physician and usually also an eye surgeon.

An ophthalmologist has first completed the full course of medical studies, received the degree of M.D., served an internship in general medicine and surgery in an approved hospital, and has then taken special training in ophthalmology. Like the family physician, the ophthalmologist and all other medical specialists are licensed to practice all branches of medicine and surgery.

Oculist is a less commonly used name for ophthalmologist.

Other terms which you should understand in connection with eye care are:

An Optician is a skilled technician, auxiliary to medicine, who supplies and fits glasses on the prescription of a physician. He is trained to make the necessary facial measurements; to formulate the specifications necessary, and to make the glasses or other appliances; and to adapt them to the patient, placing them properly in relation to the eyes. He supplies glasses or other appliances only on the doctor's authorization.

An Optometrist is a licensed person who has met certain legal and educational

requirements and is permitted by the state to engage in the practice of optometry. He is not a physician or doctor of medicine. The word *optometry* comes from two Greek words—*opto* meaning "eye," and *meter*, "measure." The optometrist measures the focus of the eye for glasses. He is not qualified or permitted to use drugs for these tests or for any other purpose. He is not qualified or permitted to diagnose or to treat ocular disease. He may supply glasses on his own prescription. In most states he is also permitted, like the optician, to fill the ophthalmologist's prescription for glasses. By law he is a limited practitioner.

Southern Medical Association Meeting Held at Miami Beach

The Fifty-First Annual Meeting of the Southern Medical Association, held at Miami Beach, November 11 to 14, 1957, was the major medical event in Florida during that month. Over 300 scientific papers in 100 different meetings were presented before the 20 sections, comprising one of the world's largest medical meetings. Some 5,000 physicians and their wives were in attendance, and many social affairs enlivened the occasion. More than 50 medical association officials and specialists from Cuba and other Latin American countries were present.

At the closing night session, Dr. W. Kelly West of Oklahoma City was installed as president. Dr. Milford O. Rouse of Dallas was chosen president-elect to take office next year, and Dr. Edward H. Lawson of New Orleans was named first vice president. Dr. Donald F. Marion of Miami, chairman of the Greater Miami Committee on Arrangements for the meeting, was elected second vice president.

The broad scope of the scientific sessions had wide appeal to practitioners in all branches of medicine. This most complete refresher course, with discussions, all condensed within four days and held right on the doorstep of Florida physicians, gave them an unusual opportunity for professional stimulus, of which many took advantage. Members of the Florida Medical Association in large numbers participated in the program as essayists, panel members, moderators and discussants.

Among the group of Florida physicians presenting papers at the meeting were the following: Coral Gables: Philip Samet, Hyman Turken, William H. Bernstein. Daytona Beach: Thomas E. Scott Jr. Fort Lauderdale: Curtis D. Benton Jr. Fort Myers: Joseph L. Seldon Jr. Gainesville: Charles H. Carter, J. Maxey Dell Jr., George T. Harrell Jr., William C. Thomas Jr. Jacksonville: Joseph A. J. Farrington, J. Champneys Taylor, G. Dekle Taylor. Miami: Theodore J. C. Von Storch, Ralph E. Kirsch, John E. Burch, William A. D. Anderson, John G. Chesney, Robert B. Lawson, Benedict R. Harrow, Bertrand E. Lowenstein, Samuel Gertman, Robert J. Boucek, Walter W. Sackett Jr., Francis N. Cooke, E. Sterling Nichol. Ocala: William H. Turnley. Pensacola: Chas. J. Heinberg, Gretchen V. Squires. Tampa: Sherman B. Forbes, Mason Trupp, James N. Patterson, J. Brown Farrior, C. MacKenzie Brown, Wesley W. Wilson, J. M. Ingram Jr., Robert W. Withers, Henry L. Wright Jr. Winter Park: Nila K. Covalt.

Dade County Medical Association Executive Office Building Dedicated

The dedication of the Dade County Medical Association Executive Office Building on Nov. 3, 1957, marked the attainment of a goal long sought. For more than two decades a home of its own was the dream and a major objective of the Dade County Medical Association. The realization more than fulfills the dream.

Presiding at the dedicatory service was Dr. Walter W. Sackett Jr., President, who welcomed the members and guests. After introductory remarks by Mrs. William P. Smith, President of the Woman's Auxiliary to the Dade County Medical Association, Dr. Edward W. Cullipher, senior member of the Board of Trustees, discussed the building, and Dr. Nelson Zivitz, President-Elect, reviewed the history of the project. Dr. William C. Roberts, President of the Florida Medical Association, was the guest speaker on this auspicious occasion.

Outstanding among buildings of its type in the nation, this first home of the Florida Medical Association's largest component county society is strategically located at 2 Southeast Thirteenth Street. On this busy corner at the intersection with Miami Avenue, it becomes the health focal point for a population center of approximately a million people. From the foundations and foot-

ings for additional height, and the attractive inside patio for the easiest and most economical expansion, to the movable partitions which allow immediate flexibility of existing floor plan, the completed building provides adequately for present and for future function. The spectacular two story structure reflects both the progressive spirit of the association and the dignity of the profession. With its many facilities offered in the public interest, it clearly portrays the association's basic purpose—to serve the physician and his patient. It now serves a membership of 1,085, a figure which is expected to be doubled within the next decade.

The association's administrative offices are on the ground floor at the left of the entrance. Facing the entrance, the precast terrazzo and steel stairs are the center of attraction in the large central patio. Beyond them is the combination doctors' lounge and board room which easily accommodates five or 50, lending an atmosphere of casual or formal discussion as the occasion may demand. This room and its connecting service facilities are used not only by the association's many committees but also by similar groups from the other organizations in the building.

Along the western corridor of the lower floor are the offices of the East Coast Dental Society and of the Woman's Auxiliary to the Dade County Medical Association. Occupying the northwest corner is the Dade County Unit of the American Cancer Society. The stairs, serving the second floor until a third floor is added and the elevator is put into use, arise from the patio to open into a semienclosed outside corridor which surrounds the offices and service rooms for the upper story. The glass partitions separating the hall from the offices are of a type which provides full flexibility for future changes in office layout and entrance requirements. On this floor are located the Medical Service Bureau and the Heart Association of Greater Miami.

Below: Dr. Walter W. Sackett Jr., President of the Dade County Medical Association (1), delivers the address of welcome at the dedication of the Association's executive office building (2). The audience of several hundred attending the ceremony (3) hears the principal address delivered by Dr. William C. Roberts, President of the Florida Medical Association (4).



The Dade County Medical Association is to be congratulated on its long range planning and wise investment in a home which is in keeping with the character and stature of its membership. Too, this great county medical society is to be commended for the breadth of vision and overall planning which enable it to share its physical facilities with allied organizations so that at the outset its new home becomes truly a health focal point for Dade County.

Statewide Medico-Legal Institute Held in Jacksonville

Sponsored by the Florida Bar and the Florida Medical Association, the second Statewide Medico-Legal Institute was held in Jacksonville on November 22 and 23, 1957. The attendance was excellent and representative of the various sections of the state.

Judge Wallace E. Sturgis and Judge John T. Wigginton of the Florida First District Court of Appeals presided over two of the three sessions. Presiding over the third session was Florida Supreme Court Justice Campbell Thornal.

A panel consisting of Dr. Lucien Y. Dyrenforth, Dr. Ashbel C. Williams and the Hon. C. C. Howell Jr. presented the first topic, "Relationship of Cancer and Trauma." The subject of "Trauma and Strain on the Cardiovascular System" was discussed by Dr. Karl B. Hanson, Dr. James E. Cousar III and the Hon. Jack F. Wayman. "Electromyograph as an Aid in Evaluating Nerve and Muscle Injury" was a subject which evoked particular interest. It was presented by Dr. Simon Markovich, a pioneer in this field, and Dr. Ben J. Sheppard.

The second session opened with the presentation of "Crash Syndrome," a subject presented by Dr. Paul W. Braunstein, a member of the Cornell University Crash Team. "Whiplash" injuries were discussed by Dr. Richard A. Worsham and the Hon. Walter Beckman Jr. The final subject of the day was "Post Concussion Syndrome." Dr. Edward J. Sullivan Jr. and Dr. William H. McCullagh discussed the anatomic aspects and the Hon. Roger J. Waybright the legal aspects.

The Saturday morning session opened with a discussion of "Back Injury, Its Cause and Sequelae," presented by Dr. Charles B. Mabry and the Hon. T. Paine Kelly. The final subject, entitled "Disability Evaluation," was presented by a panel composed of Dr. Vernon T. Grizzard Jr., Dr. George I. Raybin, the Hon. John E. Mathews Jr. and the Hon. Harry T. Gray.

Arrangements for the meeting were in charge of Dr. Sheppard, who is chairman of the Florida Bar's committee on medicolegal law and procedures, and Dr. W. Tracy Haverfield, who is the member of the Florida Medical Association's public relations advisory committee responsible for liaison with the legal group. A social hour and dinner at the George Washington Hotel, where all sessions were held, concluded the Friday portion of the program. The next institute will be held in Tampa late next month.





The discussion of "Disability Evaluation" was presented by the panel shown at left, (seated) Attorneys John E. Mathews Jr. and Harry T. Gray, and Dr. George I. Raybin; (standing) Dr. Vernon T. Grizzard Jr. and Justice of the Florida Supreme Court Campbell Thornal. Judges of the First District Court of Appeals attending the Institute are shown at right with Dr. Paul W. Braunstein. They are (left to right) Judge John T. Wigginton, Judge Donald K. Carroll, Dr. Braunstein, and Judge Wallace E. Sturgis.

Dr. Babers Addresses District Meetings

At the District Meetings, held last October, Dr. Henry J. Babers Jr., Chairman of the Advisory Committee to Blue Shield, unofficially known as the Committee of Seventeen, made a timely address which will be of particular interest to every member of the Association. The text of his remarks follows:

It seems that the whole world is in controversy. The French cannot agree among themselves on anything and are just about done for. The middle East is aflame. Our country is beset by a number of serious controversies. So, perhaps our own problems in the medical profession, smaller but just as upsetting, are other symptoms of a general disease. This disease is the apparent inability of men at this particular time in history to understand common problems and to work them out peacefully and decently. Yet, diseases can be cured or at least arrested. The world has been in controversy many times before and has survived. Surely we can work out our problems in medicine in statesmanlike fashion.

The Blue Shield program in Florida is certainly a controversial subject. It is quite capable, along with many other economic problems, of being a disruptive influence unless we resolve our mistrusts and misunderstandings.

The facts are these:

1. The Blue Shield operation is a force in the economic life of every doctor. It is so complex and poorly understood that the doctor does not really identify himself with it. A new generation of doctors has come along since the original plan was put into action. Yet, Blue Shield is completely dominated by doctors, your colleagues. Actually, when you criticize Blue Shield you are criticizing yourselves and your medical leadership. Doctors have a tendency to blame Blue Shield, as if they had no part in it, and direct their criticism at the administrative portion of Blue Shield. This Blue Shield controversy must be put into proper perspective. It is an intramedical problem and must be understood as such.
2. Blue Shield is at the crossroads now. Laboriously built up by the medical profession to a large corporation, it has been put into an untenable position. Blue Shield is just barely breaking even and is in serious danger of collapse. Doctors who control it have so hamstrung its activities that, like the French Government, it cannot move.

In 1956 President Langley appointed an FMA committee of 17 doctors to study this serious problem. Approximately the same group was reappointed by President Roberts this year. Please look up the make-up of this committee, which is conservative and one of the most sincere groups I have ever worked with. Certainly, we have not been any apologists for Blue Shield. This committee work has been a real chore; most of us have studied long and hard, conscientiously and with all good faith. We have been fair in our approach in spite of what some doctors believe. We believe that what must be done is this:

1. The doctors in FMA must decide definitely and in great majority whether they will support Blue Shield or not. The present situation cannot go on as it is. The present situation, if unchanged, guarantees that Blue Shield go backward and will doom it most surely. If the membership desires to discontinue Blue Shield, then let's say so and get it over. If the majority of doctors in Florida want to support Blue Shield wholeheartedly, let's do it well and right and let's agree one way or another and not pick ourselves to death.

You all know our committee sent editorials to you and have recently put out a comprehensive survey. From our editorial replies and the survey replies one thing is quite obvious. In general, whether they know it or not, the doctors are hopelessly confused as to what they really want and are hopelessly inadequate at present to understand how they can get what they want.

Our membership has little knowledge of the economic forces in action in this nation in respect to medical practice; and the knowledge of Blue Shield, their own organization, is abysmal. Before you can adequately make a decision on this very serious problem you must, for your own benefit, know more about it. We are beginning to get some ideas from our editorial and survey answers, but so far it is too early to say much. In general, it appears that about 25 per cent of

the doctors are opposed to any real support of the Blue Shield program. About 75 per cent are in favor of support if adequate changes can be made to make it equitable.

We have had criticism (mostly quite fair and reasonable, with a few unfairly prejudiced persons and societies) in reference to our survey. My answer to this is how would you do it in our shoes and what alternatives would you offer? Would you be willing to work? If so, I feel sure we can use your help. This is a thankless job, but some one has to do it, and we are honestly interested, challenged by what we have learned, and willing to work.

2. We are supporting an informational meeting of the active members of Blue Shield to be held on Saturday, December 7, in Jacksonville. Here we hope to give each doctor who represents you and your society a chance to get at least some information on the Blue Shield operation. Your representative then must go back to your society and acquaint everyone possible with the facts. So we urge you for your own good to insist that your delegates, your active voting member of Blue Shield, be present at this meeting.

We intend to continue our program of information to each of you, through editorials, through making ourselves available to you personally and to your societies, and through every means available.

When you are better informed by the time of the next annual meeting of FMA in the spring of 1958, the House of Delegates of FMA should then be able to decide definitely whether to support Blue Shield or not. This will be a momentous decision and must not be taken lightly. We will give you the facts fairly; you must discuss them adequately and be prepared to act on them at the next annual meeting of FMA. It is only after such a general decision is made that, if you desire to continue Blue Shield, specific and long overdue changes in the fee schedule, service limits, and premium rates can adequately be adjusted.

Surely we can work out our problems in medicine in a statesmanlike fashion. We "ain't mad at nobody" and please be fair and "don't nobody get mad at us." Let's not be like my friend, Tom Hickey, a young Irish orderly at New York Hospital where I interned. One Monday morning he came in, obviously badly battered and bruised. "For goodness sakes, Tom," I asked, "what happened?" "I really don't know, doctor. I saw these two guys fighting and I got into it."

1958 Mediclinics of Minnesota Fort Lauderdale, March 2-12

The third annual postgraduate refresher course presented by Mediclinics of Minnesota will be held at Governor's Club Hotel in Fort Lauderdale on March 2 to 12, 1958. The American Academy of General Practice has certified this course for 32 hours of formal postgraduate study, Category I, for the Academy members in attendance.

The course consists of 32 hours of lectures and panels conducted by a faculty well able to present the varied subjects in the several fields of medicine. The lecturers, all members of the faculty of the University of Minnesota Medical School, and their subjects are: Harold F. Buchstein, M.D., Neurosurgery; Thomas P. Cook, B.S.; Harry B. Hall, M.C., Orthopedics; Arthur C. Kerkhof, M.D., Internal Medicine; Francis W. Lynch, M.D., Dermatology; Ames W. Naslund, M.D., Roentgenology; O. L. Norman Nelson, M.D., Internal Medicine; Owen F. Robbins, M.D., Obstetrics and Gynecology; Albert V. Stoesser, M.D., Pediatrics; Robert J. Tenner, M.D., Proctology; and Richard L. Varco, M.D., Surgery. The panel subjects are: Other Complications of Pregnancy, Childhood Problems, Gastrointestinal Tract in Childhood, Burns, Systematic Use of Laboratory Methods, Jaundice, Pulmonary Problems, Aftermaths of Poisoning, Heart Disease Today, Accidental Trauma, Office Practice, The Problems in Anemia, Medical-Legal Panel, and Your Hour with the Consultants.

The experience gathered in 1956 and 1957 requires that registration be limited to 300 in order to preserve the informal and intimate atmosphere in the lecture room. There is every assurance that this number of registrants and their wives can be comfortably accommodated in Fort Lauderdale at the peak of the tourist season if reservations are made well in advance. Both the time of year and the limited number accepted make early registration particularly important.

The course is sponsored by the Florida Academy of General Practice. Requests for an application should be sent to Walter J. Glenn, M.D., 1106 East Broward Boulevard, Fort Lauderdale.

Dr. Glenn is Chairman of the Education Committee of the Florida Academy of General Practice and is in charge of arrangements for the meeting.

Occupational Medicine Conference Miami, Aug. 18-22, 1958

The Second Conference on Occupational Medicine, sponsored jointly by the University of Havana School of Medicine, Havana, Cuba, and the University of Miami School of Medicine, will be held in Miami, Aug. 18-22, 1958. Dr. William B. Deichmann, Professor of Pharmacology at the University of Miami School of Medicine, is chairman of the conference, and Dr. M. Eugene Flipse, Associate Professor of Medicine, is chairman of the program committee. Dr. Francisco Lancis y Sanchez, president of the Cuban Industrial Medical Society, and Dr. Rafael Penalver Ballina of the University of Havana School of Medicine, are members of the planning committee. Proceedings of the conference will be in Spanish. Inquiries regarding attendance or papers may be referred to Dr. Deichmann at the University of Miami School of Medicine, Coral Gables.

The first occupational medicine conference sponsored by the two schools of medicine, held in Miami, Sept. 3-6, 1956, brought together 76 specialists in industrial medicine and toxicology from Cuba, Venezuela, Peru, Mexico, Puerto Rico, Spain, Chile and Colombia, as well as from eight states of the United States. This conference, the first to be conducted in Spanish on American soil, considered all phases of industrial and occupational medicine, ranging from the effects of disease states on work in various industries to the substances producing industrial poisoning.

The University of Miami has sought to encourage cooperative educational and cultural programs with countries of the Caribbean and South and Central America. The School of Medicine, located at the natural gateway to the Latin Americas, is the medical education facility of continental United States nearest to medical centers of the southern hemisphere. As a result, it has become for many Latin American countries the focus for informal discussion of medical problems and also for continuing postgraduate education and the development of inter-American research programs.

Physician Celebrates Golden Anniversary of Career

On completion of a half century of service as a practicing physician, Dr. I. Kimbell Hicks of Melbourne was locally honored on Oct. 29, 1957. At a dinner party given by Mr. and Mrs. Robert Young, his son-in-law and only daughter, he visited with physicians and other friends, some of whom could remember with him back to the time when he arrived in Melbourne and began taking an active part in the business, professional, civic and social affairs of the budding community.

The Melbourne Kiwanis Club declared the previous evening Kim Hicks Night and issued an official proclamation to that effect. In it the members paid high tribute to Dr. Hicks as a charter member and a past president who had given generously of his time and talent to many phases of civic life as well as to the practice of his chosen profession.

Dr. Hicks entered the practice of medicine on Oct. 29, 1907, in Jackson, Ala., in the office of his father, Dr. L. O. Hicks, after graduation from the University of the South in Sewanee, Tenn. In 1915 he came to Florida, interned at St. Luke's Hospital in Jacksonville while preparing for Florida examinations, and while there met Miss Grace Hoag, a student nurse, to whom he was married on Aug. 5, 1916. From 1917 to 1921 he was associated with Dr. Ralph E. Smith, an outstanding Jacksonville physician.

In 1922, Dr. Hicks located in Melbourne, where he has continued to engage in the general practice of medicine for 35 years. He has served the entire community faithfully and well and in point of service is the senior of all active practitioners in Brevard County. When Dr. Hicks arrived in Melbourne, the only physicians in the vicinity were Dr. I. F. Bean and Dr. William J. Creel of Eau Gallie. There was no hospital, but a short time afterward, Dr. Isaac M. Hay, a surgeon, arrived and opened The Crenshaw Hospital, a private institution. Dr. Hicks became its staff anesthetist, a position he held for 25 consecutive years. Dr. Creel and Dr. Hay were among the guests attending the fiftieth anniversary dinner.

In addition to caring for a thriving practice, Dr. Hicks through the years has entered wholeheartedly into every civic project. He is a charter member of the Melbourne Civic Improvement Board, a charter member and organizer of the Melbourne Hunting and Fishing Club, and



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1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.



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for several years he has been an active member and director of the First Federal Savings and Loan Association of Brevard County. In 1950 he and Mrs. Hicks, who died two years later, were organizing charter members of the Eastminster Presbyterian Church in Indialantic and he has served as an elder there since that time.

In 1934 and 1935, Dr. Hicks was Mayor of Melbourne, and after serving as City Commissioner from 1936 to 1941, he was again elected Mayor in 1942. During his chairmanship of the City Commission in 1937, he officiated at the ground-breaking ceremony for the new Brevard Hospital, which he helped to organize. For 20 years he was the secretary of the Brevard County ty Medical Society.

During the World War II years, Dr. Hicks was the only general practitioner in Melbourne, serving the 7,000 residents of the community. At the same time he was Mayor, Acting Judge and Chief of Staff at the hospital.

In an editorial congratulating Dr. Hicks on the golden anniversary of his career as a practicing physician, the Melbourne Daily Times paid him this tribute:

"Few men reach a fifty-year milestone in their profession and at the same time have hundreds of persons wish them well because of diversified contributions made to a community. . . . Your contributions to South Brevard, where you have spent thirty-five years, are too numerous to recount and too valuable to be correctly judged, except in an over-all picture.

"We know of few civic groups which have not been aided in some way by your foresight. We know there must have been countless bedside vigils which taxed your strength, your knowledge and your human concern for fellow man.

"We deeply respect your profession, Dr. Hicks, but even more do we respect your appreciation of the fact that health and happiness apply not only to body but also to heart and soul. We are grateful to you, and men like you, who believe in healing and strengthening.

"In thirty-five years you have seen many changes in Brevard County. It is our hope that you are as proud today of the community you serve as the community is proud of you.

"We are going to take liberty in signing this letter to you, Dr. Hicks. We think everyone in this area will be pleased if we sign it not with our own name but in the name of

The People Who Know You"

Dr. Hicks' career of diversified service extending across half a century offers an inspiring example to his busy professional colleagues. The Florida Medical Association and its official organ, The Journal, salute this distinguished member whose life and works reflect great credit not alone upon him but also upon the profession whose dignity, honor and ideals he upholds.

Central Florida Medical Meeting Orlando, March 13, 1958

The Fourth Annual Central Florida Medical Meeting will be held Thursday, March 13, in Orlando. This meeting is sponsored by the Orange County Medical Society. Participating in the program will be outstanding men in various fields. Dr. Frank Glenn, Professor of Surgery, Cornell University Medical College, and Surgeon-in-Chief, New York Hospital, will discuss "Peptic Ulcer." Dr. L. W. Diggs, Professor of Medicine and Director of the Clinical Laboratory, University of Tennessee College of Medicine, will speak on "Treatment of Hemorrhagic Diseases" and "Hemolytic Anemias." Dr. Robert Anderson, Assistant Commissioner of Mental Hygiene for the State of Ohio, Columbus, Ohio, and formerly Manager, Winter Veterans Administration Hospital, Topeka, Kan., will discuss "The Role of Anxiety in Illness." Dr. Robert B. Lawson, Professor of Pediatrics, University of Miami School of Medicine, will have as his topics "Use of Steroids in Children" and "Advances in Pediatrics."

Registration for the meeting will begin at 8 a.m. The annual banquet will terminate the program in the evening.

For the first time, the speakers this year will conduct informal question and answer discussions. Following the formal papers, they will meet with small groups of interested physicians who may ask questions regarding the papers. At these sessions they may also ask questions regarding problems that they may have in their own practice.

The 1957 meeting was well received by the 300 physicians who attended. General practice credits were granted last year to general practitioners who attended, and it is expected that the 1958 meeting will also be approved for credit.

All physicians throughout the state are cordially invited to be present and bring their wives. Activities for the wives are planned.

Cardiovascular Diseases Annual Seminar Jacksonville, Feb. 20-22

The Fifth Annual Seminar on Cardiovascular Diseases will be held on Thursday, Friday and Saturday, February 20, 21 and 22, 1958, at the Prudential Auditorium in Jacksonville. This course is presented by the Northeast Florida Heart Association and is endorsed by the Florida Heart Association. It is co-sponsored by the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida State Board of Health and the Florida Medical Association, and has been accepted by the American Academy of General Practice for formal postgraduate study in Category I.

The lecturers for the course are Dr. Samuel Bellet, Professor of Clinical Cardiology, University of Pennsylvania Graduate School of Medicine, Director, Division of Cardiovascular Diseases, Graduate Hospital of the University of Pennsylvania, and Director, Division of Cardiology, Philadelphia General Hospital; Dr. George E. Burch, Professor of Medicine and Chairman of the Department of Medicine, Tulane University School of Medicine; Dr. Denton A. Cooley, Associate Professor of Surgery, Baylor University College of Medicine; and Dr. Ben I. Heller, Professor of Medicine, University of Arkansas School of Medicine.

Dr. Bellet will discuss cardiac arrhythmias and cardiac resuscitation; Dr. Burch, coronary disease, hypertension, and electrocardiology; Dr. Cooley, pump-oxygenator machines, open heart surgery, aneurysmal repairs, and blood vessel grafts, and Dr. Heller, electrolytes in congestive heart failure, and renal physiology in congestive heart failure.

LETTER TO THE EDITOR

Dear Sir:

In the October issue of The Journal, Dr. George Gittelson has called timely attention to a too frequently neglected phase of the management of bronchial asthma. In pointing this out, however, the casual reader may feel that he has undervalued the role of hyposensitization in the treatment or prevention of asthma. Many men who treat vasomotor rhinitis and an occasional bronchitis feel that hyposensitization to specific agents when they are found may truly prevent later supervention of asthma. The simile he draws that "hyposensitization without elimination is like prescribing glasses for a man with no eyes" is unfortunate. I believe it would be more accurate to state, using his simile, that hyposensitization without elimination is like a person with no eyes prescribing glasses for one who has some vision even though imperfect.

It should also be pointed out that mold spore formation in the depths of foam rubber pillows is now well documented and is a contaminant that is very difficult to remove. The newer dacron floss pillows do quite as well as a head rest and have the advantage of nonmildewing and a ready ease of soap and water cleansing and very rapid drying. Further, the dacron floss does not dry crumble and form dust.

Dr. Gittelson is to be commended for reminding all of us that allergic cleanliness is next to health godliness. All of our general readers would do well to follow his sound advice.

Yours respectfully,
Clarence Bernstein, M.D.

OTHERS ARE SAYING

Editorial

A recent article in the Miami Herald "Business and Finance" column quotes from a marketing survey by Life Magazine that most families with incomes of $4,000 or less per year are spending more money than they earn. "The desire to own and consume goods exceeds the ability to earn with a substantial segment of Americans." 47% of all U. S. households fall in the income category of $4,000 or less, and this poses a serious problem in furnishing adequate medical care to this large segment of the population, and in receiving compensation for your services.

There have been many changes in the past several years which have helped create this situation, in addition to inflation. Installment buying of furniture, cars, T.V.'s and almost everything a family uses has become a universal custom. The tremendous productive capacity of industry has forced dealers to sell for "little or nothing down" and "a little each week." Check-offs from the weekly pay check for taxes, union dues, and insurance complete the picture.

Sickness is rarely expected, and until the advent of hospitalization and sickness insurance it was almost never provided for. As long as nothing happens to hamper the earning power of the

breadwinner, and as long as there are no unexpected expenses, the lower income families go along without too much difficulty. When serious illness strikes, then this precarious equilibrium is thrown out of balance. When an individual suddenly is faced with heavy medical expenses and unable to meet his obligations, he is embarrassed and unhappy. If the pressure becomes too great, then he may move to another town or change doctors. Either way, you are not paid and you lose the patient.

It is not enough merely to say that he should have saved money for the emergency and he would not have been in his predicament. The solution to this problem lies in continued support and expansion of voluntary health insurance with service category for low-income groups. The only company to which we can safely extend service features is Blue Cross and Blue Shield, a company in which the doctors have an important role in determination of policies. If all the people in the $4,000 or under income group who apparently do not have the capacity or inclination to save for illness are holders of Blue Cross-Blue Shield insurance, they can have adequate medical care, and we can be justly compensated for our work. Then I doubt if these people can be tempted to turn to the Federal government for their medical care.

Richard L. Foster, M.D.,
Editor, The Record,
Broward County Medical Association
October 1957.

Medical District Meetings. 1957

The Eighteenth Annual Medical District Meetings were held October 28 at Panama City, October 29 at Clearwater, October 30 at Orlando and October 31 at Fort Pierce. Total registration for the four sessions was 289 members of the Florida Medical Association and 47 visitors.

The diagnosis and management of gastrointestinal bleeding, both medical and surgical, was the scientific subject discussed at each of the meetings. The program was arranged by Dr. S. Carnes Harvard, of Brooksville, chairman of the Council of the Association, with the assistance of the district councilors.

Among the prominent guests at each meeting were the deans of the two medical schools in Florida, Dr. Homer F. Marsh, School of Medicine, University of Miami, Dr. George T. Harrell Jr., College of Medicine, University of Florida, and Mr. Thomas A. Hendricks, Field Director, American Medical Association.

The program for each of the four general sessions include an explanation of the function of the Florida Medical Foundation, by Dr. Edward Jelks, of Jacksonville, and a discussion of Medicare by Dr. John D. Milton, Miami; Blue Shield by Dr. Henry J. Babers Jr., Gainesville, and World Medical Association and Rural Health by Dr. Francis T. Holland, Tallahassee. Also featured at each general session were short addresses by the President of the Association, Dr. William C. Roberts; President-Elect, Dr. Jere W. Annis, and Secretary-Treasurer, Dr. Samuel M. Day.

Northwest Medical District
October 28 — Panama City

Dr. Harvard presided at the meeting, assisted by Dr. Alpheus T. Kennedy, Councilor for District 1, during the scientific assembly, and by Dr. T. Bert Fletcher Jr., Councilor for District 2, during the general session.

Dr. John J. Benton, president of the Bay County Medical Society, delivered the address of welcome, and following, Dr. Charles J. Kahn, of Pensacola, discussed "Diagnosis and Medical Management of Gastrointestinal Bleeding," and Dr. Frank E. Tugwell, of Pensacola, "Diagnosis and Surgical Management of Gastrointestinal Bleeding."

The 1958 meeting will be held in Marianna. Total registration was 66, of which 53 were Association members (45 from this district) and 13 visitors. Among those attending were past presidents Dr. John D. Milton, Dr. Julius C. Davis and Dr. Edward Jelks.

Registration

BLOUNTSTOWN: Grayson C. Snyder. BROOKSVILLE: S. Carnes Harvard. CHATTAHOOCHEE: William D. Rogers. DE FUNIAK SPRINGS: William D. Cawthon, Ralph B. Spires. GAINESVILLE: Henry J. Babers Jr., George T. Harrell Jr. GRACEVILLE: Redden L. Miller, William W. Richardson. JACKSONVILLE: Samuel M. Day, Edward Jelks, Lorenzo L. Parks. LAKELAND: Jere W. Annis. MARIANNA: James T. Cook Jr., Albert E. McQuagge, Richard H. Schulz, Sarah M. Schulz, Francis M. Watson. MIAMI: John D. Milton. PANAMA CITY: Daniel M. Adams Jr., Donald H. Anderson, John J. Benton, Jack Corbitt, Charles H. Daffin, Sidney E. Daffin, William C. Fontaine, John J. Hollomon Jr., William F. Humphreys Jr., John H. Kay,

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Specifically, the usefulness of Dartal has been established in psychoneuroses with emotional hyperactivity, in diseases with strong psychic overtones such as ulcerative colitis, peptic ulcer and in certain frank and senile psychoses.

Usual Dosage • In psychoneuroses with anxiety and tension states *one 5 mg. tablet t.i.d.*

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Michael J. Lingo, Joseph H. Morris, James D. Nixon, James M. Nixon, William C. Roberts, C. W. Shackelford, Harold E. Wager, Roderick C. Webb. PENSACOLA: Constantine A. Asters, Bernard M. Barrett, Frank L. Creel, Frank B. Hodnette, Samuel G. Holmes, Charles J. Kahn, Alpheus T. Kennedy, Wendell J. Newcomb, Frank E. Tugwell, Lockland V. Tyler Jr., Earl G. Wolf. PORT ST. JOE: John W. Hendrix. QUINCY: Julius C. Davis. TALLAHASSEE: Francis T. Holland, Robert H. Mickler, Henry L. Smith Jr.

VISITING DOCTORS: PANAMA CITY: Daniel C. Campbell, John L. Fishel, David M. Jewett, Leo E. Reilly, Jack E. Sanders, Henry C. Smallwood.

OTHER GUESTS—ATLANTA: Leyton B. Hunter. CORAL GABLES: Homer F. Marsh, Ph.D. JACKSONVILLE: Ernest R. Gibson, Eugene L. Nixon, W. Harold Parham, H. A. Schroder. PENSACOLA: Luther L. Smith Jr.

Southwest Medical District
October 29 — Clearwater

During the scientific assembly, Dr. Harvard was assisted as presiding officer by Dr. Gordon H. McSwain, Councilor for District 6, and at the general session by Dr. John M. Butcher, Councilor for District 5.

Dr. Percy H. Guinand, president of the Pinellas County Medical Society, delivered the address of welcome, and Dr. George D. Hopkins II, of Fort Myers, discussed "Diagnosis and Medical Management of Gastrointestinal Bleeding," and Dr. Richard A. Martorell, of Tampa, "Diagnosis and Surgical Management of Gastrointestinal Bleeding."

At the general session, Fort Myers was selected as the meeting place for 1958. Total registration was 91, of which 76 were Association members (69 in this district) and 15 visitors. Among those registered were past presidents Dr. Edward Jelks, Dr. John D. Milton and Dr. Francis H. Langley.

Registration

ARCADIA: Gordon H. McSwain. BROOKSVILLE: S. Carnes Harvard. CLEARWATER: Lawrence R. Buckley, James P. Burns Jr., Douglas W. Carr, Raymond H. Center, Helen L. T. Dexter, James V. Freeman, John T. Goodgame, Lewis A. Gryte, Percy H. Guinand, Everett M. Harrison, Francis C. Hoare, J. Sudler Hood, John T. Karaphillis, Charles H. Lasley, John A. Lauer Jr., James B. Leonard, Raymond M. Lockwood, William G. Mason, Sherman H. Pace, Samuel T. Register, Henry E. Smoak Jr., Robert P. Vomacka, Thomas H. Wallace, Robert M. Wolff. DADE CITY: John S. Williams. DUNEDIN: James C. Fleming, John A. Mease Jr., Virgil D. Smith, James F. Spindler, Walter H. Winchester. FORT MYERS: George D. Hopkins II, John S. Stewart. GAINESVILLE: George T. Harrell Jr., JACKSONVILLE: Samuel M. Day, Edward Jelks, Lorenzo L. Parks. LAKELAND: Jere W. Annis, Marion W. Hester. MIAMI: John D. Milton. NEW PORT RICHEY: Frank Y. Robson. PANAMA CITY: William C. Roberts. PLANT CITY: Madison R. Pope. PUNTA GORDA: Walter B. Clement, Roscoe S. Maxwell. ST. PETERSBURG: Henry J. Jensen, Francis H. Langley, Whitman C. McConnell, Whitman H. McConnell, John B. O'Neill, Howard L. Reese. SAFETY HARBOR: David P. Wollowick. SARASOTA: John M. Butcher, Melvin M. Simmons, Henry J. Vomacka. TALLAHASSEE: Francis T. Holland. TAMPA: Samuel H. Adams, Harold O. Brown, Joseph D. Brown, Leffie M. Carlton Jr., Robert H. Soffer, Richard G. Connar, Herschel G. Cole, Joshua C. Dickinson, Samuel G. Hibbs, Alexander J. Kelly, Richard A. Martorell, Eugene B. Maxwell, James N. Patterson, Zack Russ Jr., Marshall E. Smith, Mason C. Smith, Wesley W. Wilson. TREASURE ISLAND: James W. Allee.

VISITING DOCTORS: CLEARWATER: Morris W. Dexter, Harold Gross, R. T. Snider. DUNEDIN: Philip B. Paty, William T. Williams. HOLMES BEACH: Trave L. Brown Jr. TAMPA: William M. Douglas, Harold L. Sanders. FAIRBORN, OHIO: Theodore H. Winans.

OTHER GUESTS—ATLANTA: Leyton B. Hunter. CORAL GABLES: Homer F. Marsh, Ph. D. GAINESVILLE: Cash B. Pollard, Ph. D. JACKSONVILLE: Ernest R. Gibson, Eugene L. Nixon, W. Harold Parham, H. A. Schroder.

Northeast Medical District
October 30 — Orlando

Assisting Dr. Harvard as presiding officers were Dr. Leo M. Wachtel, Councilor for District 3, during the scientific assembly, and Dr. Don C. Robertson, Councilor for District 4, at the general session.

Following the address of welcome by Dr. Frank J. Pyle, president of the Orange County Medical Society, Dr. Frank C. Bone, of Orlando, discussed "Diagnosis and Medical Management of Gastrointestinal Bleeding" and Dr. James M.

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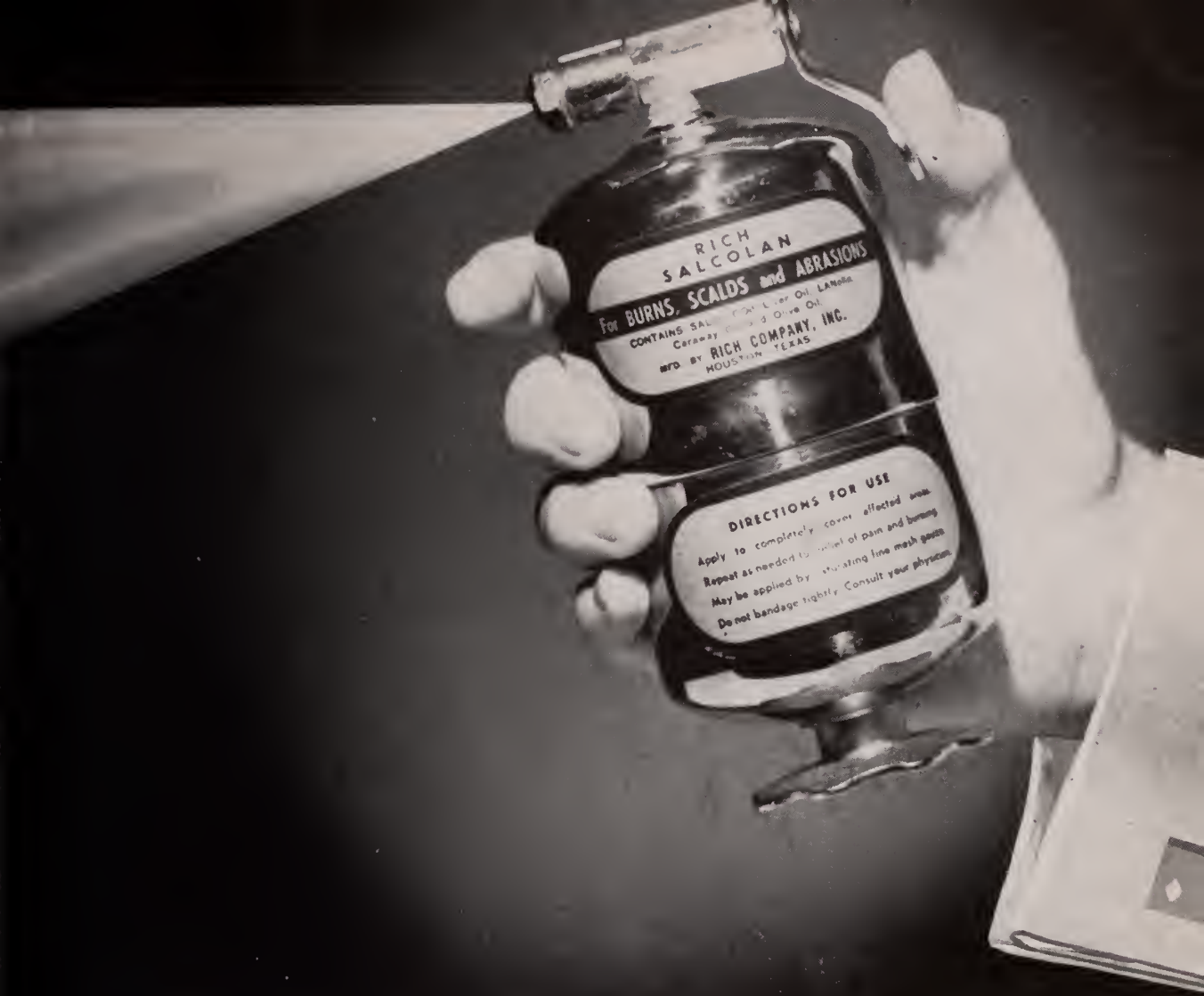
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Davis, of Jacksonville, "Diagnosis and Surgical Management of Gastrointestinal Bleeding."

The 1958 meeting is to be held at Cocoa according to decision reached during the general session. Total registration was 109 of which 101 were Association members (95 from this district) and eight visitors. Past presidents attending were Dr. Edward Jelks, Dr. Frederick J. Waas, Dr. John D. Milton, Dr. Eugene G. Peek Sr., Dr. Duncan T. McEwan, Dr. William C. Thomas Sr. and Dr. Herbert E. White.

Registration

BROOKSVILLE: S. Carnes Harvard. CLERMONT: Thomas D. Weaver. COCOA: A. F. Thomas. DAYTONA BEACH: John J. Cheleden, C. Robert DeArmas, Alphonsus M. McCarthy, Russell C. Smith. EUSTIS: Raymond A. Debo. GAINESVILLE: Eugene H. Cummings, Allen Y. DeLaney, George T. Harrell Jr., John E. Maines Jr., Samuel P. Martin, William C. Thomas Sr. JACKSONVILLE: Charles D. Cooksey, James E. Cousar III, James M. Davis, Samuel M. Day, Edward Jelks, A. Mackenzie Manson, Kenneth A. Morris, Nelson A. Murray, Arthur R. Nelson, C. Burling Roesch, Clarence M. Sharp, John H. Terry, Frederick J. Waas, Leo M. Wachtel, Edward C. Watt. LAKELAND: Jere W. Annis. LEESBURG: George E. Engelhard, Marion B. O'Kelley. MELBOURNE: Jack T. Bechtel, Arthur C. Tedford. MIAMI: John D. Milton. MOUNT DORA: J. Basil Hall, Robert H. Montgomery, Fred A. Vincenti. NEW SMYRNA BEACH: Thomas D. Cook. OCALA: William H. Anderson Jr., Henry L. Harrell, John D. Lindner, Eugene G. Peek Sr., Eugene G. Peek Jr. ORLANDO: Benjamin L. Brock, Thomas C. Butt, J. Rocher Chappell, Chas. J. Collins, Herbert W. Collins, Thomas R. Collins, William R. Daniel, James G. Economon, Horace A. Day, Roger C. Floren, Oscar W. Freeman, Raymond C. Haley Jr., Keith L. Hanson, Thomas F. Hegert, Harold W. Johnston, Morton Levy, Duncan T. McEwan, Carl S. McLemore, James A. McLeod, Meredith Mallory, J. William Martin, Fred Mathers, William S. Mitchell, James D. Moody, Charles A. Murray, Franklin G. Norris, Louis M. Orr, Frank M. Parish, Roger E. Phillips, Frank J. Pyle, Joseph G. Seltzer, Charles R. Sias, Freeman D. Stanford, W. Dean Steward, Sam N. Sulman, Robert L. Tolle, A. Fred Turner Jr., Jack P. Ward, Robert E. Zellner. OVIEDO: Edward W. Stoner. PANAMA CITY: William C. Roberts. ROCKLEDGE: J. Robert Doty, Myron L. Habegger, Louis C. Jensen Jr., ST. AUGUSTINE: Reddin Britt, Herbert E. White. SANFORD: Orville L. Barks, J. Clifford Boyce, Daniel H. Mathers, Harry Z. Silsby. TALLAHASSEE: Francis T. Holland. TAVARES: James R. Hanson. WEST PALM BEACH: Cecil M. Peek. WINTER PARK: Dorothy T. Clark, Duane C. Deen, Charles D. Price, Henry J. Wiser.

VISITING DOCTORS: CLERMONT: Thomas H. Nichols. GAINESVILLE: S. R. Woodward.

OTHER GUESTS—ATLANTA: Leyton B. Hunter. CORAL GABLES: Homer F. Marsh, Ph.D. JACKSONVILLE: Ernest R. Gibson, Eugene L. Nixon, W. Harold Parham, H. A. Schroder. ORLANDO: Mrs. Berneice T. Mathis.



Southeast Medical District
October 31 — Fort Pierce

Presiding with Dr. Harvard were Dr. Ralph M. Overstreet Jr., Councilor for District 7, during the scientific assembly, and Dr. Nelson Zivitz, Councilor for District 8, during the general session.

Dr. John M. Gunsolus, president of the St. Lucie-Okeechobee-Martin County Medical Society, delivered the address of welcome, and following, Dr. Fred E. Manulis, of Palm Beach, discussed "Diagnosis and Medical Management of Gastrointestinal Bleeding," and Dr. Richard M. Fleming, of Miami, "Diagnosis and Surgical Management of Gastrointestinal Bleeding."

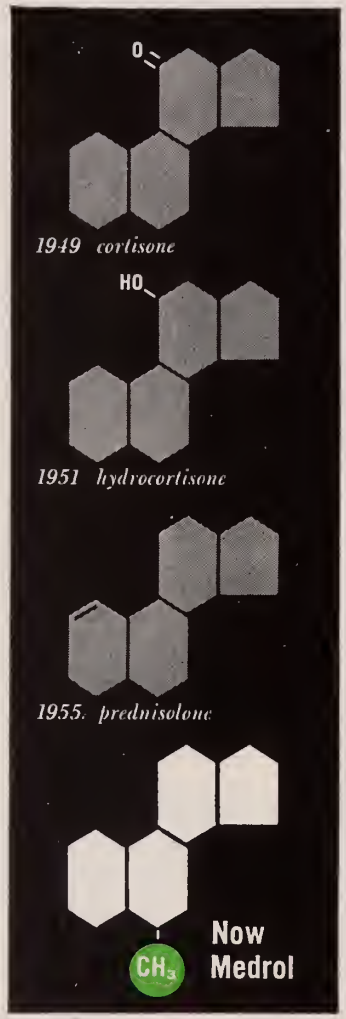
The 1958 meeting is to be held at Miami. Total registration was 70, of which 59 were Association members (50 from this district) and 11 visitors. Among those registered were past presidents Dr. John D. Milton, Dr. Frederick K. Herpel and Dr. Edward Jelks.

Registration

BELLE GLADE: Wilbert O. Norville (Col.). BOYNTON: Charles D. Akes. BROOKSVILLE: S. Carnes Harvard. CORAL GABLES: Anna A. Darrow, Warren W. Quillian. FORT PIERCE: Joseph H. Batsche, Alfred J. Cornille, Russell L. Counts, Hugh B. Goodwin Jr., Martin G. Gould, Howard C. McDermid, Adrian M. Samples, Wilbur S. Turner, Richard F. Sinnott, George Theodorou, Lester L. Whiddon, Melvin Wolkowsky, Lloyd U. Young. GAINESVILLE: Henry J. Barbers Jr., George T. Harrell Jr. JACKSONVILLE: Samuel M. Day, Edward Jelks, Clarence M. Sharp. LAKELAND: Jere W. Annis. LAKE WORTH: James H. Rester Jr., A. Scott Turk, Edward W. Wood. MIAMI: Reuben B. Chrisman Jr., Edward W. Cullipher, Richard M. Fleming, W.

(Continued on page 744)

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a major
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minor chemical changes can mean major therapeutic improvements

Medrol*

The most efficient of all anti-inflammatory steroids

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Upjohn

(Continued from page 742)

Tracy Haverfield, Ralph W. Jack, Truxton L. Jackson, John D. Milton, Winston K. Shorey. MIAMI BEACH: Nelson Zivitz. PALM BEACH: Arthur P. Kaupe, Fred E. Manulis. PANAMA CITY: William C. Roberts. STUART: John M. Gunsolus, Julian D. Parker. TALLAHASSEE: Francis T. Holland. VERO BEACH: Melton D. Council, William L. Fitts 3rd, Vernon L. Fromang, B. Bowman Guerin, Kip G. Kelso. WEST PALM BEACH: Willard F. Ande, John M. Baber, Edwin W. Brown, Victor Clarholm, James F. Cooney, Joseph J. Daversa, Frederick K. Herpel, V. Markin Johnson, Edgar A. P. Kellerman, Philip O. Lichtblau, W. Ambrose McGee, Lloyd J. Netto, Ralph M. Overstreet Jr.

VISITING DOCTORS: JENSEN BEACH: Richard Q. Penick. SEBASTIAN: Harold F. Albert. WEST PALM BEACH: Taufick E. Bendeck, Richard D. Hoover, Jackson L. Thatcher, Malcolm S. Van de Water.

OTHER GUESTS—ATLANTA: Leyton B. Hunter. CORAL GABLES: Homer F. Marsh, Ph.D. JACKSONVILLE: Ernest R. Gibson, Eugene L. Nixon, W. Harold Parham.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Aye, Ralph C., Tampa
Ernst, Conrad F., Crystal River
Lanford, William S., Indialantic
Miller, Neill D., Fort Pierce
Morton, Donald G., Melbourne
Wiswell, Orville O., Cocoa

STATE NEWS ITEMS

Dr. Louis M. Orr of Orlando attended the Eleventh General Assembly of the World Medical Association held in Istanbul, Turkey, as a member of the Board of Directors. While abroad, he visited clinics and hospitals in France, Italy, Switzerland, Germany, Holland and England.

Drs. Ruth S. Jewett and Eugene L. Jewett of Orlando attended the annual meeting of the Society of Orthopedic Surgery and Traumatology held in Colombia, South America. Dr. Eugene L. Jewett presented two papers during the meeting; one entitled "The Place of Replacement Prosthesis and Hip Joint Trauma;" the other "The Rigid Internal Fixation of Intracapsular Femoral Neck Fractures."

Dr. Albert M. Ziffer of Orlando appeared on the program of the scientific assembly of the American Heart Association held in Chicago. The title of his paper was "Hemodynamic Effects of Vasodilatation Induced by Sodium Nitrate in Congestive Heart Failure: Relationship to Starling's Law of the Heart."

when anxiety and tension "erupts" in the G. I. tract...

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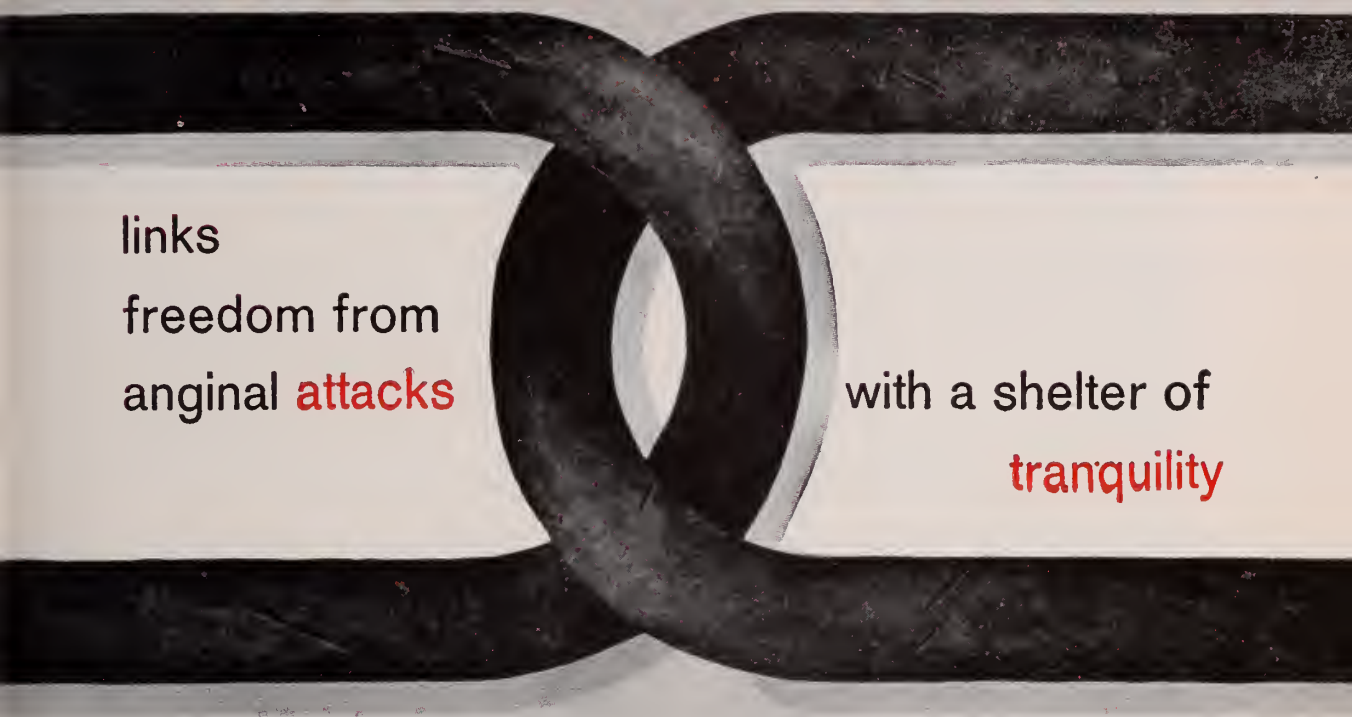
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PETN + ATARAX®

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links
freedom from
anginal attacks

with a shelter of
tranquility

In pain. Anxious. Fearful. On the road to cardiac invalidism. These are the pathways of angina patients. For fear and pain are inexorably linked in the angina syndrome.

For angina patients—perhaps the next one who enters your office—won't you consider new CARTRAX? This doubly effective therapy combines PETN (pentaerythritol tetranitrate) for lasting vasodilation and ATARAX for peace of mind. Thus CARTRAX relieves not only the anginal pain but reduces the concomitant anxiety.

Dosage and supplied: begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated, this may be increased for more optimal effect by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100. CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

"Cardiac patients who show significant manifestations of anxiety should receive ataractic treatment as part of the therapeutic approach to the cardiac problem."[1]

1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

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Dr. Alvan G. Foraker of Jacksonville attended the meeting of the Intersociety Cytology Council in Augusta in mid-November, participating in a panel discussion on intraepithelial carcinoma of the cervix. Dr. Foraker also attended meetings of the Advisory Cytology Committee, formed to advance research in this field.

Dr. Kenneth G. Gould Sr. of Tampa recently served a special two week tour of active service during which he visited United States Air Forces bases in Germany, France and England. Dr. Gould is a colonel in the United States Air Force Reserve.

Dr. Wilson T. Sowder of Jacksonville, State Health Officer, has been elected a director of the State and Territorial Health Officers Association.

Dr. William M. C. Wilhoit of Pensacola has been elected president of the Florida Mental Health Association. Dr. Wilhoit is a member of the Committee on Mental Health of the Florida Medical Association.

Dr. Mason Trupp of Tampa has been awarded a citation for his distinguished work in medicine by the Washington College Alumni Association. Dr. Trupp received the Bachelor of Science degree at the Chestertown, Md., college in 1933.

Dr. Reuben J. Plant Jr. of St. Augustine has been re-elected president of the St. Johns County Welfare Federation.

Dr. Albert V. Hardy of Jacksonville has been appointed assistant state health officer, a position recently created by the Florida State Board of Health.

Dr. James R. Sory of West Palm Beach has returned from the Medical College of Georgia at Augusta where he did postgraduate work in endocrinology.

Dr. Daniel B. Langley of Naples discussed the importance of the Rh factor in human blood at a recent meeting of the Rotary Club of that city.

Dr. Nelson H. Kraeft of Tallahassee addressed the Leon County Chapter of the Florida Federation of Social Workers on some of the

(Continued on page 752)

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Monilial
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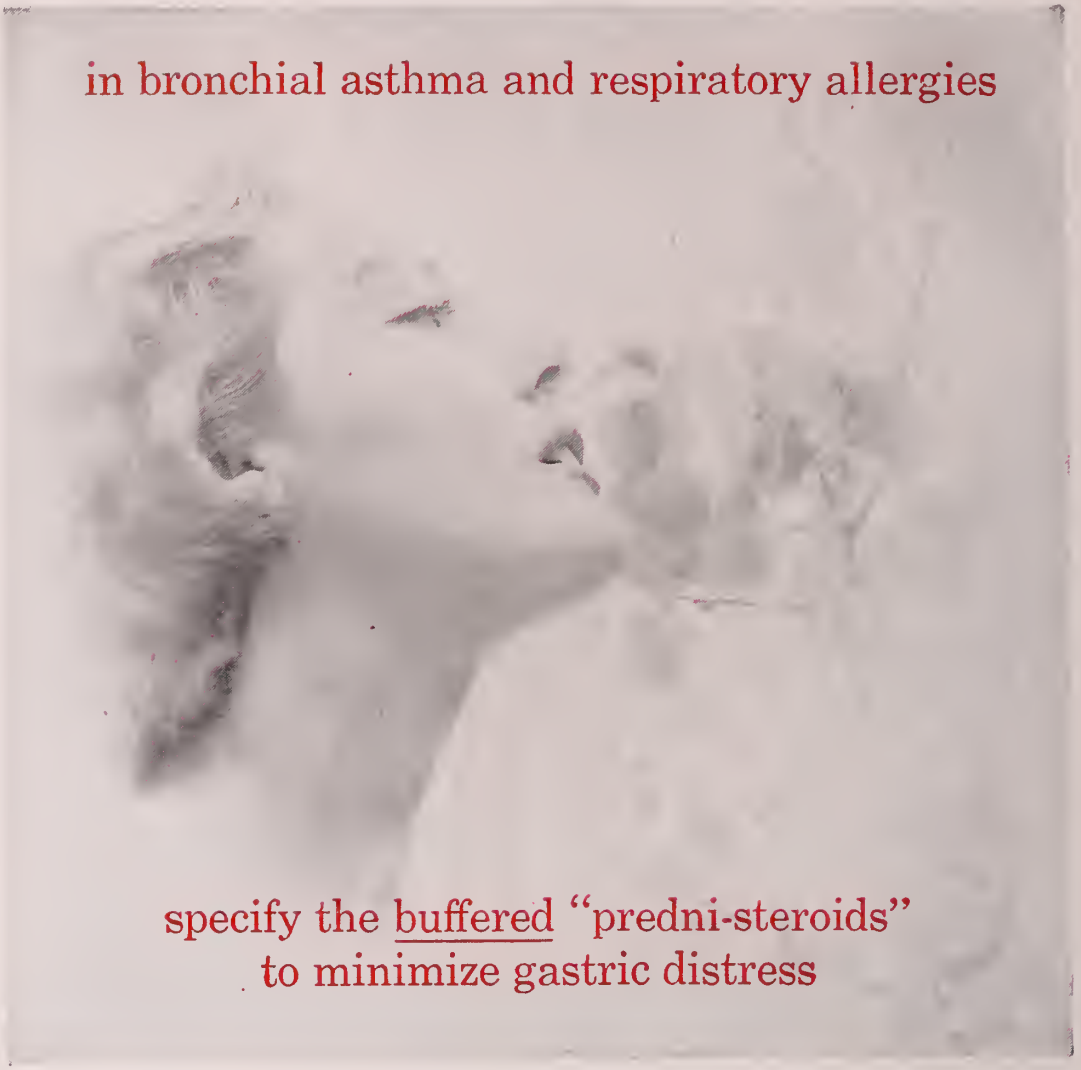
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(Prednisone buffered)

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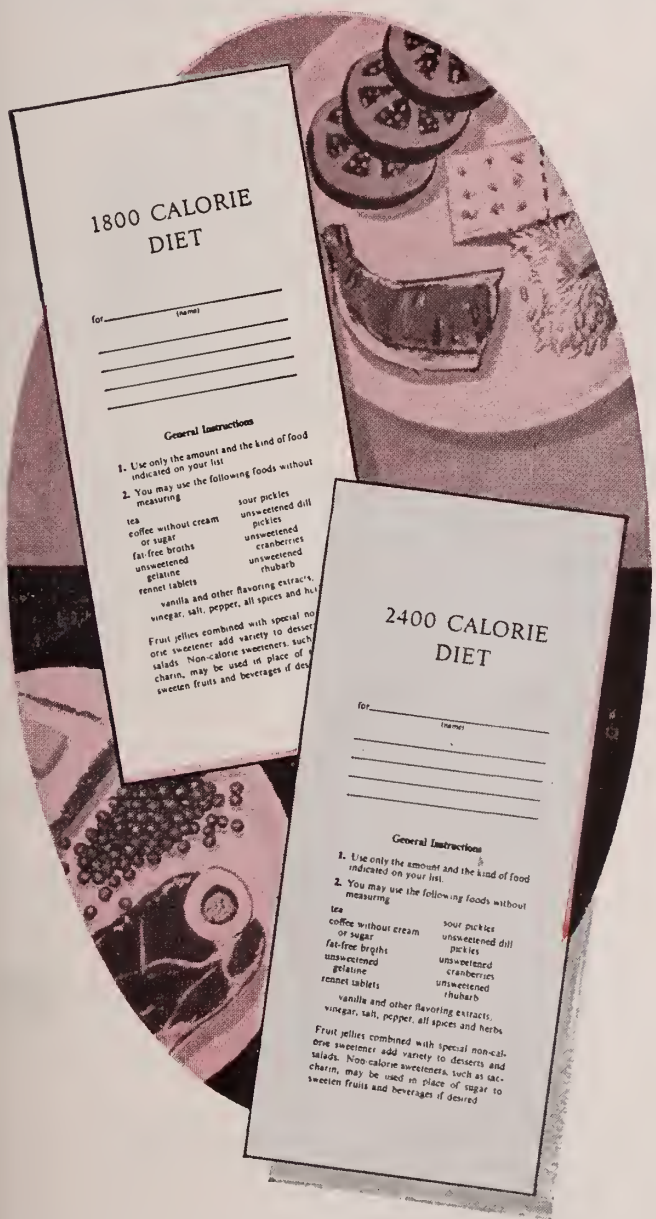
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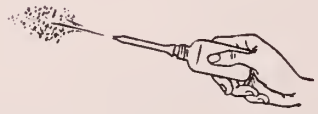
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(Continued from page 746)

psychological and sociological aspects of cancer at a meeting of the group in October.

Dr. Howard V. Weems Sr. of Sebring has been honored by the Rotary Club there for his 35 years service as a physician to the community.

Drs. Arnold H. Eichert and Jess V. Cohn of Hollywood discussed "The Steps Leading Into and Out of Mental Hospitals" at the October meeting of the Woman's Auxiliary to the Broward County Medical Association held at the home of Mrs. Scottie J. Wilson.

Dr. Henry G. Morton of Sarasota has been installed as president of the Florida Pediatric Society. Dr. Harry M. Edwards of Ocala is serving as secretary and Dr. Fred I. Dorman of Lakeland as treasurer. Installation of Dr. Morton and the election of Drs. Edwards and Dorman took place at the Twenty-Seventh Annual Meeting of the Society held at West Palm Beach.

Dr. Aubrey Y. Covington of Starke, director of the Clay-Bradford-Union County Health Departments, has been elected first vice president of the Florida Health Officers Association.

Drs. Nelson Zivitz and S. Charles Werblow directed the activities of the medical division for the United Fund's Miami Beach campaign.

Physicians from Florida, Alabama and Mississippi attended the symposium on "The Use of Antibiotics in Infectious Diseases" held at Pensacola early in November. The symposium was sponsored by the Escambia County Medical Society in cooperation with the Lederle Laboratories Division of the American Cyanamid Co. Drs. Paul F. Baranco, president of the Society, Barkley Beidelman and John M. Packard, all of Pensacola, served as presiding officers for the various sessions.

Fifty members of the Southern Flying Physicians gathered at Miami Beach during the recent annual meeting of the Southern Medical Association. Dr. Donald W. Smith of Miami served as chairman of the local arrangements committee for the meeting. Dr. Walter G. Robinson of Palm Beach is president and Dr. Edwin H. Andrews of Gainesville is secretary.



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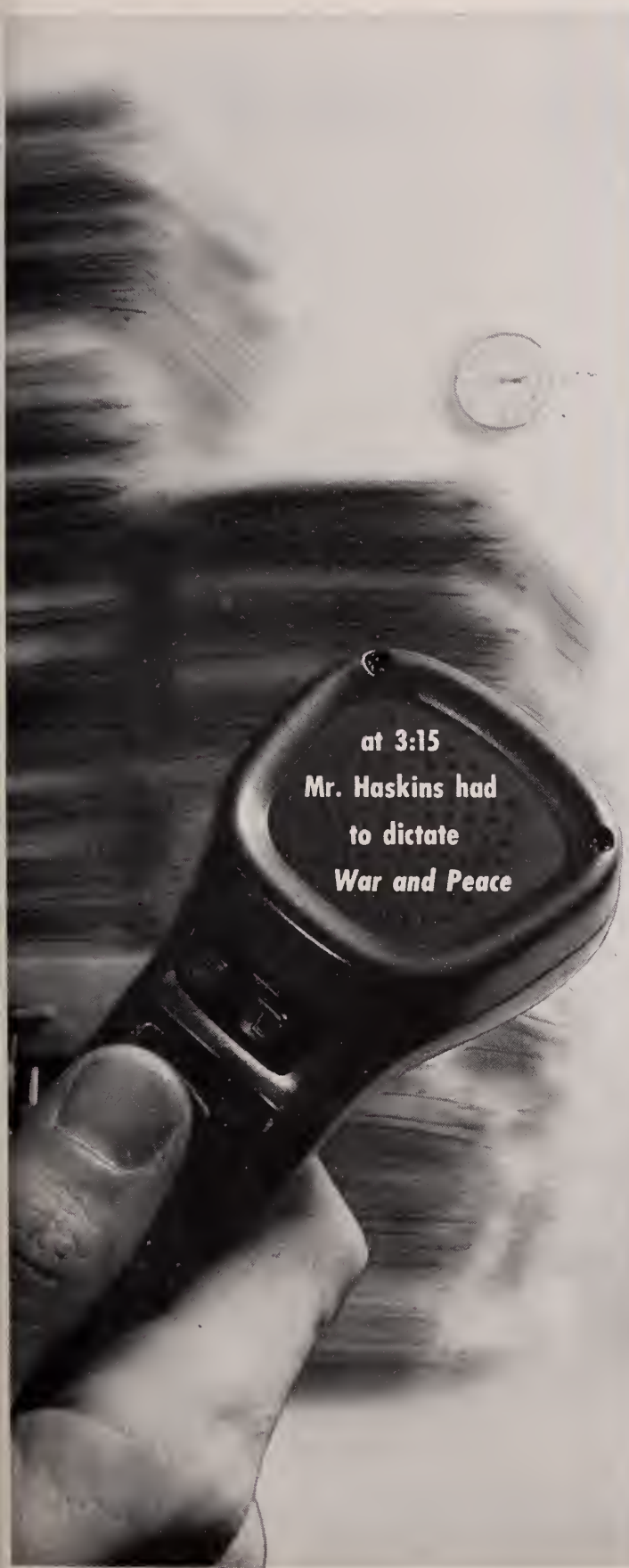
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so does the patient

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1. Comparative Effects of Various Rauwolfia Alkaloids in Hypertension; *submitted for publication.*

Dr. George A. Dame of Jacksonville was honored for his "great devotion and high service to the cause of public health" by the Florida Public Health Association at its Twenty-Ninth Annual Meeting held at Fort Lauderdale, October 31-November 2.

Dr. Milton S. Saslaw of Miami has been appointed governor for the state of Florida of the American College of Cardiology.

The College of Medicine of the University of Florida at Gainesville has received a grant from the National Institutes of Health to provide for laboratories for a broad health research program. The grant will be used in the construction of an addition to the present Medical Sciences Building.

A Symposium on the Management of Cardiovascular Problems of the Aging has been planned for April 12, 1958, at Miami Beach, according to announcement by Dr. O. Whitmore Burtner of Miami, chairman of the Symposium Committee of the Dade County Medical Association. It is being sponsored by the Association and the pharmaceutical firm of J. B. Roerig & Company.

The first Oklahoma Colloquy on Advances in Medicine to be devoted to problems in fluid, electrolyte and nutritional balance has been scheduled for Feb. 6-8, 1958 at the University of Oklahoma School of Medicine. Information may be obtained from the Division of Postgraduate Education, University af Oklahoma School of Medicine, Oklahoma City, Okla.

Drs. Raymond H. King of Jacksonville and William W. Richardson of Graceville have been appointed to the Advisory Council for Hospital Licensure to the Florida State Board of Health by Governor LeRoy Collins.

The Atlanta Graduate Medical Assembly has been scheduled for Feb. 17-19, 1958, in the Atlanta Biltmore Hotel at Atlanta. Subjects include medicine, surgery, obstetrics and gynecology, neurology and psychiatry, neurosurgery, pathology, pediatrics, radiology and urology. Advance registration is possible by contacting the Atlanta Graduate Medical Assembly, 875 W. Peachtree Street, N.W., Atlanta, attention Mrs. Shafer. The fee is $10.



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ACHROMYCIN ® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
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Bottle of 24 tablets

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Each teaspoonful (5 cc.) contains:

ACHROMYCIN ® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
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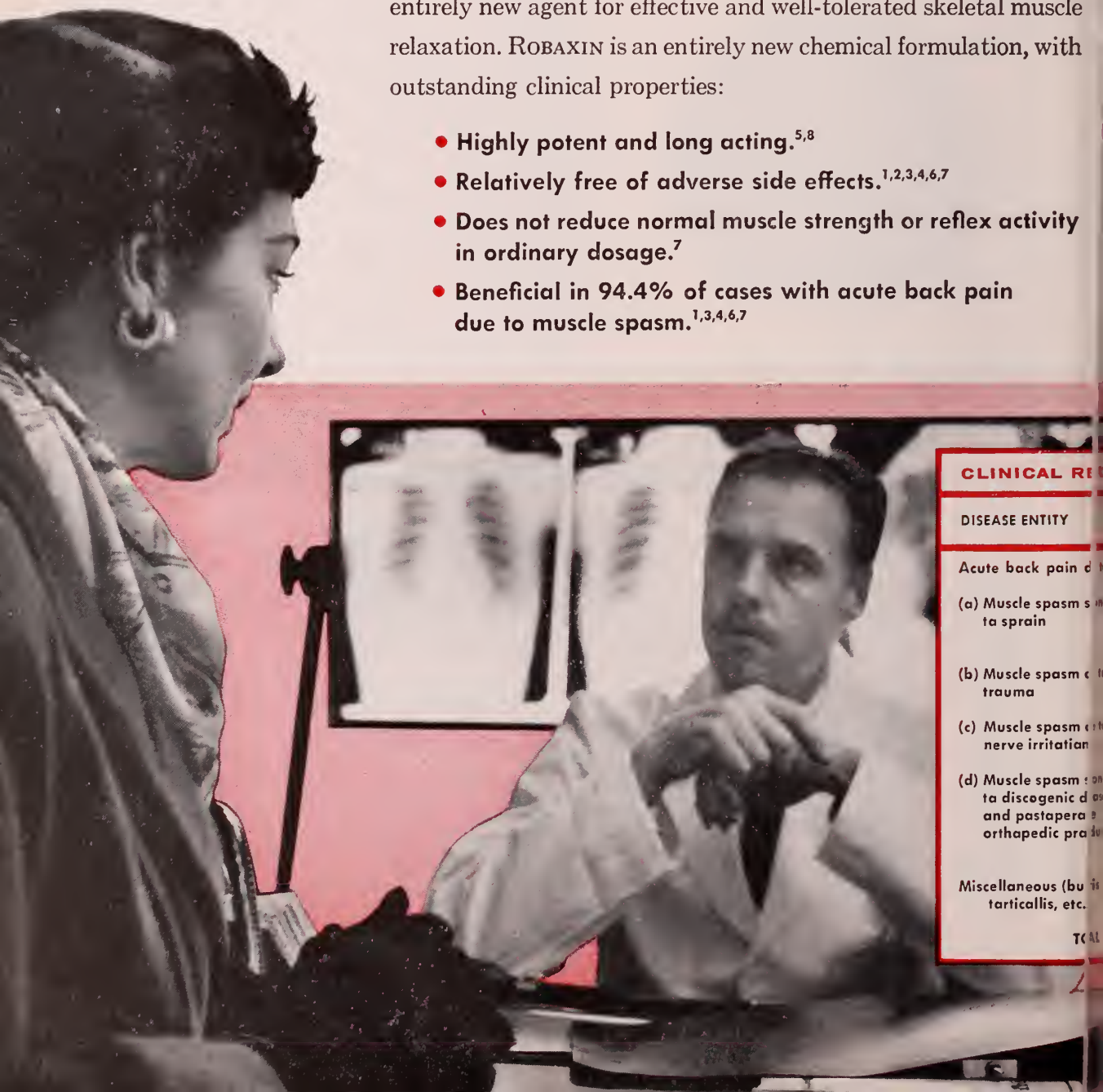
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- **Highly potent and long acting.**[5,8]
- **Relatively free of adverse side effects.**[1,2,3,4,6,7]
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ROBAXIN is highly specific in its action on the internuncial neurons of the spinal cord – with inherently sustained repression of multisynaptic reflexes, but with no demonstrable effect on monosynaptic reflexes. It thus is useful in the control of skeletal muscle spasm, tremor and other manifestations of hyperactivity, as well as the pain incident to spasm, without impairing strength or normal neuromuscular function.

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When tested in 72 patients with acute back pain involving muscle spasm, ROBAXIN induced marked relief in 59, moderate relief in 6, and slight relief in 3 – or an over-all beneficial effect in 94.4%.[1,3,4,6,7] No side effects occurred in 64 of the patients, and only slight side effects in 8. In studies of 129 patients, moderate or negligible side effects occurred in only 6.2%.[1,2,3,4,6,7]

ROBAXIN IN ACUTE BACK PAIN[1,3,4,6,7]

DURATION OF TREATMENT	DOSE PER DAY (divided)	RESPONSE marked	mod.	slight	neg.	SIDE EFFECTS
2-42 days	3-6 Gm.	17	1	0	0	None, 16 Dizziness, 1 Slight nausea, 1
1-42 days	2-6 Gm.	8	1	3	1	None, 12 Nervousness, 1
4-240 days	2.25-6 Gm.	4	1	0	0	None, 5
2-28 days	1.5-9 Gm.	24	3	0	3	None, 25 Dizziness, 1 Lightheadedness, 2 Nausea, 2 *
3-60 days	4-8 Gm.	6	0	0	0	None, 6
		59	6	3	4	*Relieved on reduction of dose

References: 1. Carpenter, E. B.: Publication pending. 2. Carter, C. H.: Personal communication. 3. Forsyth, H. F.: Publication pending. 4. Freund, J.: Personal communication. 5. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: American Pharm. Assn. 46:374, 1957. 6. Nachman, H. M.: Personal communication. 7. O'Doherty, D.: Publication pending. 8. Truitt, E. B., Jr., and Little, J. M.: J. Pharm. & Exper. Therap. 119:161, 1957.

Indications – Acute back pain associated with: (a) muscle spasm secondary to sprain; (b) muscle spasm due to trauma; (c) muscle spasm due to nerve irritation; (d) muscle spasm secondary to discogenic disease and postoperative orthopedic procedures; and miscellaneous conditions, such as bursitis, fibrositis, torticollis, etc.

Dosage – Adults: Two tablets 4 times daily to 3 tablets every 4 hours. Total daily dosage: 4 to 9 Gm. in divided doses.

Precautions – There are no specific contraindications to Robaxin and untoward reactions are not to be anticipated. Minor side effects such as lightheadedness, dizziness, nausea may occur rarely in patients with unusual sensitivity to drugs, but disappear on reduction of dosage. When therapy is prolonged routine white blood cell counts should be made since some decrease was noted in 3 patients out of a group of 72 who had received the drug for periods of 30 days or longer.

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WANTED: Information regarding locations. Florida licensed. One year rotating internship; one year general surgical residency. Plans General Practice. Write 69-252, P. O. Box 2411, Jacksonville, Fla.

POSITION WANTED: Desires association or salaried position in Ophthalmology or EENT practice. 34 years of age, white, male, Methodist. Florida license. Board eligible in Opthalmology with three years experience in EENT practice. Write P. O. Box 69-253, P. O. Box 2411, Jacksonville, Fla.

FOUND: Black mechanical pencil on registration desk at Called Meeting of House of Delegates in Jacksonville, December 8. Owner should contact Florida Medical Association, P. O. Box 2411, Jacksonville, Fla.

COMPONENT SOCIETY NOTES

Brevard

Dr. Jack T. Bechtel, of Eau Gallie, has assumed the office of president of the Brevard County Medical Society following his election at the Society's November meeting. Dr. Louis C. Jensen Jr., of Rockledge, was chosen as vice president, and Dr. Cyrus E. Warden, of Melbourne, secretary-treasurer.

Dr. J. Rocher Chappell, of Orlando, chairman of the Committee on Civil Defense and Disaster of the Florida Medical Association, was principal speaker at the November meeting. He discussed civil defense as it applies to medical personnel.

The Society has paid 100 per cent of its state dues for 1957.

Bay

The Bay County Medical Society has paid 100 percent of its state dues for 1957.

Lake

The Lake County Medical Society and its Woman's Auxiliary held its annual joint meeting with the Lake County Bar Association on Novem-

(Continued from page 762)

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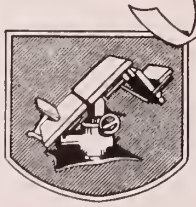
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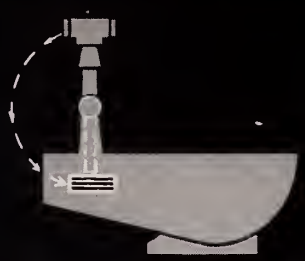
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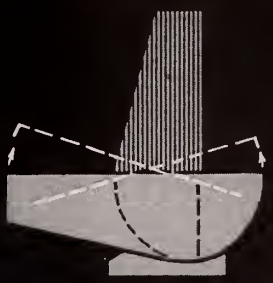
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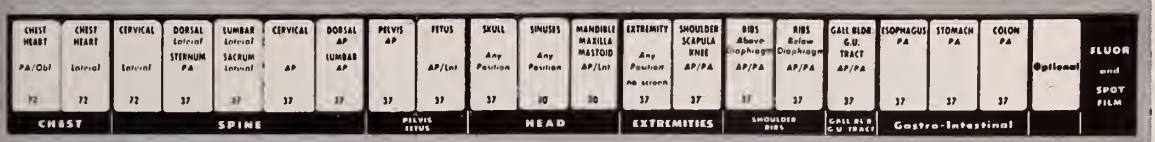


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suprel-Franol tablets bring
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ainst sudden attack. Anxiety
hen patients know they'll get
n 60 seconds — relief that con-
or four hours or more.

HCl (10 mg. for adults, 5 mg.
dren), the most potent broncho-
known, makes up the outer
In a sudden attack, the patient
tablet under his tongue. Relief
n 60 seconds. A unique feature
flavor-timer." As the Isuprel is
d a lemon flavor appears. When
pears—about five minutes later
atient swallows the tablet.

xcelled combination for pro-
bronchodilatation makes up the
-Franol core: benzylephedrine
2 mg.), Luminal® (8 mg.) and
lline (130 mg.). Swallowed, the
orks for four hours or more.

-Franol tablets are "... effec-
controlling over 80% of
s with mild to moderate
of asthma."[1]

r, J. L., and DeRisio,
hey Clin. Bull. 10:45,
, 1956.

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Rx

Isuprel-Franol Tabs
No. 100

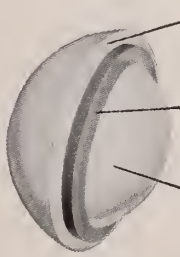
Sig 1 tablet t. p. d.
If attack occurs,
place 1 tablet under
tongue, swallow after
five minutes

ISUPREL-FRANOL
tablets (Isuprel HCl 10 mg.) for adults;
ISUPREL-FRANOL
Mild tablets (Isuprel HCl 5 mg.) for children:

One tablet every three or four hours taken *orally* for continuous control of bronchospasm in chronic asthma. One tablet taken *sublingually* for sudden attack. "Flavor-timer" signals when patient should swallow.

Bottles of 100 tablets.

"Flavor-timer" signals patients when to swallow tablets



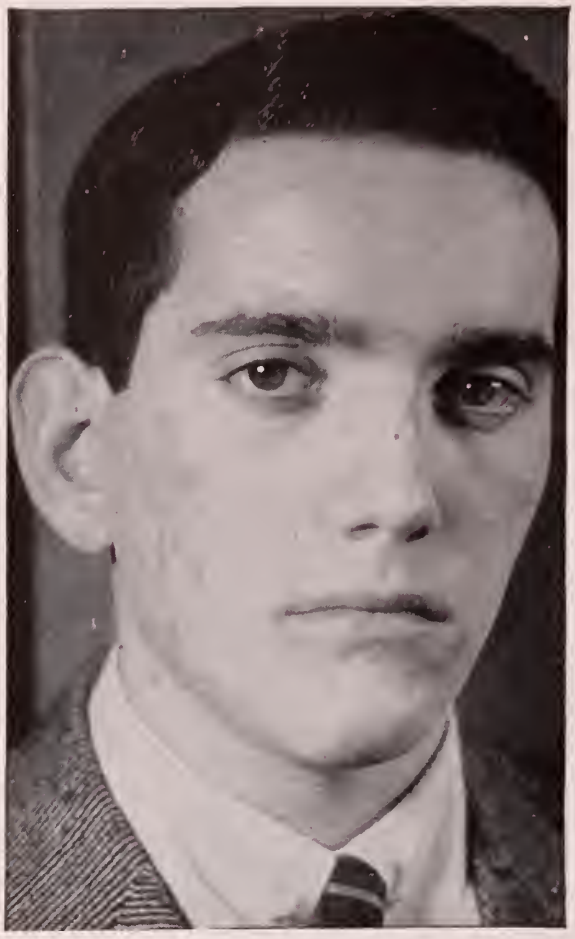
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Immediate effect sublingually—for emergency use

LEMON "FLAVOR-TIMER"
Disappearance of flavor is the signal to swallow

FRANOL { Theophylline / Luminal / Benzylephedrine
Sustained action—reduces frequency and intensity of attacks

BRAND OF ISOPROTERENOL), FRANOL AND LUMINAL (BRAND OF PHENOBARBITAL), TRADEMARKS REG. U. S. PAT. OFF.

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The greatest benefit in acne therapy comes to those patients who use pHisoHex® often and daily in conjunction with other standard measures.

For best results, prescribe from four to six pHisoHex washings of the acne area daily.

pHisoHex cleans better than soap, degerms rapidly, prevents bacterial growth, and maintains normal skin pH.

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(Continued from page 758)

ber 6 at the Silver Lake Country Club in Leesburg. Approximately 80 persons attended the dinner meeting. Mr. Wesley A. Sink and Mr. Alfred Hawkins, attorneys, gave the presentation on the subject: AMA-Bar Medico-Legal Problems.

Leon-Gadsden-Liberty-Wakulla-Jefferson

The Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society has paid 100 per cent of its state dues for 1957.

Pinellas

Dr. John P. Rowell, of St. Petersburg, was principal speaker for the December meeting of the Pinellas County Medical Society. The title of his address was "Review of Fluoridation of Water."

Putnam

Dr. Edward Jelks, of Jacksonville, a member of the Board of Governors of the Florida Medical Association, addressed members of the Putnam County Medical Society at their November meeting.

Walton-Okaloosa-Santa Rosa

The Walton - Okaloosa - Santa Rosa County Medical Society has paid 100 per cent of its state dues for 1957.

OBITUARIES

William C. Young

Dr. William C. Young died at his home in Chiefland on Aug. 18, 1957, after an illness of several months. He was 82 years of age.

Born in South Carolina in 1874, Dr. Young received his medical training in Georgia. He was awarded the degree of Doctor of Medicine by the Medical College of Georgia at Augusta in 1911 and that same year was licensed to practice medicine in Florida. He engaged actively in the general practice of medicine in Chiefland for 44 years and was a resident of Florida for 60 years. Home deliveries were routine for Dr. Young, who delivered over 3,000 babies during his career, including many of Chiefland's prominent citizens, young and old. Noted for a remarkable memory, he not only could recall the date but also the time of every delivery.

This beloved family physician was so highly esteemed in the community that a new street was named W. C. Young Boulevard in his honor last year. He was always active in church work, attending choir and prayer meetings, and until a

(Continued on page 766)



"care of the man rather than merely his stomach"[8]

"Milpath"

two-level control of gastrointestinal dysfunction

Miltown® + *anticholinergic*

at the central level The tranquilizer Miltown® reduces anxiety and tension.[1, 3, 6, 7] Unlike the barbiturates, it does not impair mental or physical efficiency.[5, 7]

at the peripheral level The anticholinergic tridihexethyl iodide reduces hypermotility and hypersecretion.

Unlike the belladonna alkaloids, it rarely produces dry mouth or blurred vision.[2, 4]

indications: peptic ulcer, spastic and irritable colon, esophageal spasm, G. I. symptoms of anxiety states.

each "Milpath" tablet contains:

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(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

Tridihexethyl iodide 25 mg.
(3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethiodide)

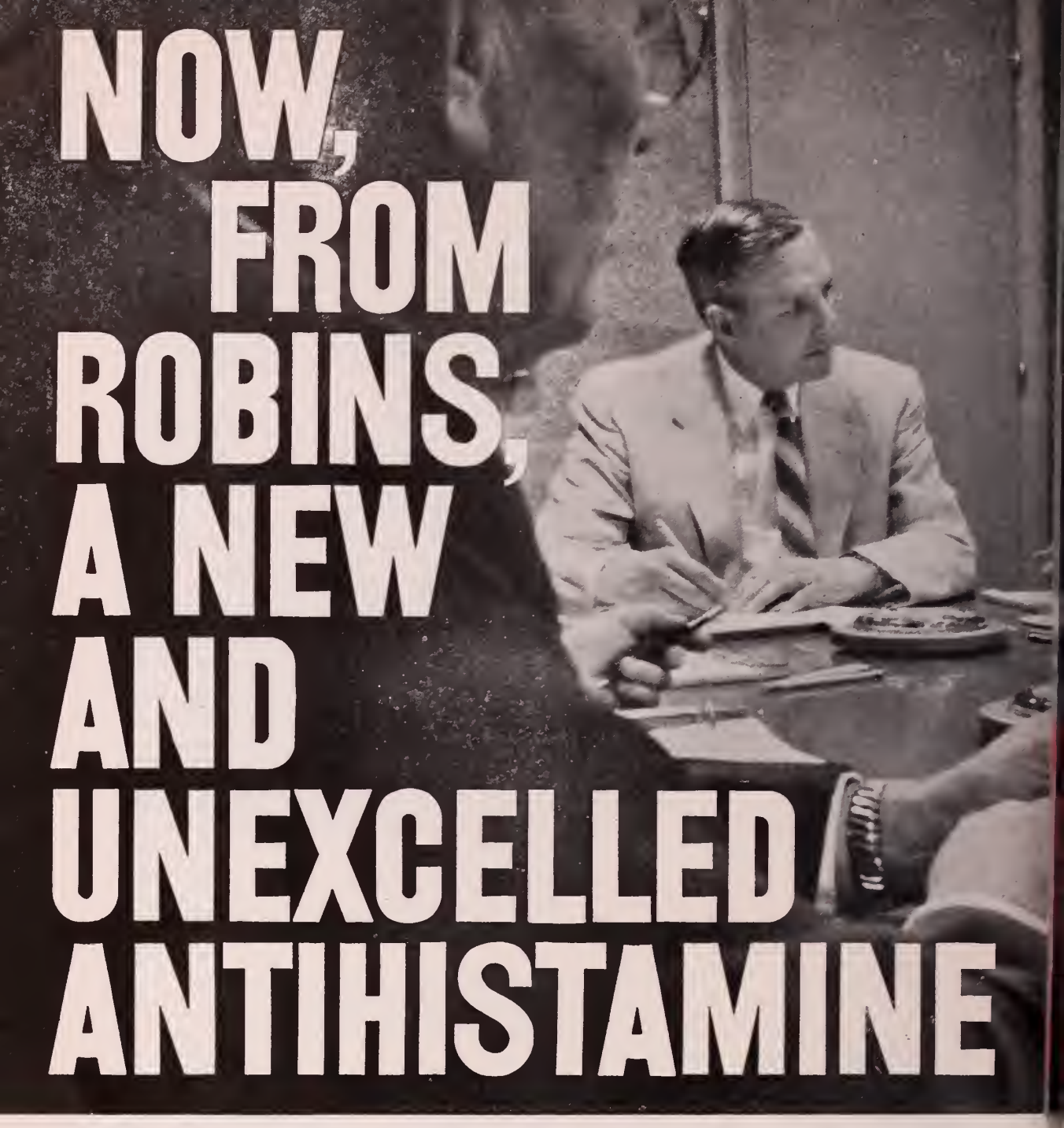
dosage: 1 tablet t.i.d. at mealtime and 2 tablets at bedtime.

available: bottles of 50 scored tablets.

references: 1. Altschul, A. and Billow, B.: The clinical use of meprobamate. (Miltown®). New York J. Med. *57*: 2361, July 15, 1957. 2. Atwater, J. S.: The use of anticholinergic agents in peptic ulcer therapy. J. M. A. Georgia *45*:421, Oct. 1956. 3. Borrus, J. C.: Study of effect of Miltown (2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate) on psychiatric states. J. A. M. A. *157*:1596, April 30, 1955. 4. Cayer, D.: Prolonged anticholinergic therapy of duodenal ulcer. Am. J. Digest. Dis. *1*:301, July 1956. 5. Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Experimental studies of behavioral effects of meprobamate on normal subjects. Ann. New York Acad. Sc. *67*:701, May 9, 1957. 6. Phillips, R. E.: Use of meprobamate (Miltown®) for the treatment of emotional disorders. Am. Pract. & Digest Treat. *7*:1573, Oct. 1956. 7. Selling, L. S.: A clinical study of Miltown®, a new tranquilizing agent. J. Clin. & Exper. Psychopath. *17*:7, March 1956. 8. Wolf, S. and Wolff, H. G.: Human Gastric Function, Oxford University Press, New York, 1947.

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the antihistamine you're now using » *Milligram for milligr*

DIMETANE potency is unexcelled. DIMETANE has a therapeutic index unrivaled b other antihistamine—a relative safety unexceeded by any other antihistamine. DIMETANE, even in very low dosage, has been effective when other antihistamines have failed. Drowsiness, other side effects have been at the very minimum.

» unexcelled antihistaminic action

Diagnosis	No. of Patients	Response				Side Effect
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Dro
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Dro
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness Dizzy (1)

From the preliminary **Dimetane Extentabs** studies of three investigators. Further clinical investigations will be reported a



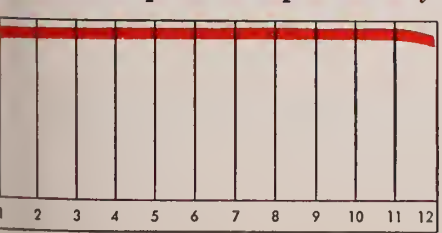
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DIMETANE IS PARABROMDYLAMINE MALEATE – EXTENTABS 12 MG., TABLETS 4 MG., ELIXIR 2 MG. PER 5 CC.

blanket of allergic protection, covering 10-12 ours—with just one Dīmetane Extentab » *DIMETANE ctentabs protect patient for 10-12 hours on one tablet.*



Periods of stress can be easily handled with supplementary DIMETANE Tablets or Elixir to obtain maximum coverage.

Dosage:

Adults—One or two 4-mg. tabs. or two to four teaspoonfuls Elixir, three or four times daily. One Extentab q.8-12 h. or twice daily.
Children over 6—One tab. or two teaspoonfuls Elixir t.i.d. or q.i.d., or one Extentab q.12h.
Children 3-6—½ tab. or one teaspoonful Elixir t.i.d.

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(Continued from page 762)
short time before his death he served as lay pastor in the Baptist Church.

Dr. Young was the oldest member of the Alachua County Medical Society. He was a life member of the Florida Medical Association and also held membership in the American Medical Association.

Immediate survivors include the widow, Mrs. Jessie Young, of Chiefland; two daughters, Mrs. Edward Kielmer, of Gary, Ind., and Mrs. Tom Barkett, of Chiefland; and two sons, Dr. Wilburn C. Young, of Canal Point, and Capt. William H. Young, United States Army, Ann Arbor, Mich. A sister, Mrs. J. P. Frierson, of Kingstree, S. C., and a brother, Harry Young, of Oklahoma City, Okla., also survive.

Ralph Frederick Allen

Dr. Ralph Frederick Allen of Miami died at Variety Children's Hospital in that city on Aug. 9, 1957, a few hours after suffering a heart attack at his home. He was 46 years of age.

A native Floridian, Dr. Allen was born in Milton. He completed high school there and then attended the University of Florida. He received his medical degree from the Tulane University School of Medicine in New Orleans in 1935. Thereafter, he served one year in the United States Public Health Service Hospital in San Francisco.

In 1937, Dr. Allen returned to Florida and entered the private practice of medicine in Miami. His specialty was proctology. Locally, he was a member of the Miami Kiwanis Club, Miami Consistory and Biscayne Bay Lodge, A.F. & A.M., and the Riviera Country Club.

During World War II, Dr. Allen served as an officer in the Navy, conducting surveys of health and sanitation in the Marshall Islands and other Pacific areas.

Dr. Allen was a member of the Dade County Medical Association and the Florida Medical Association. He also held membership in the American Medical Association, Southern Medical Association, American Proctology Association, International College of Surgeons and American Society of Tropical Medicine.

Surviving are the widow, Mrs. Eugenia Allen; a son, Raymond F. Allen, of Miami; a daughter, Mrs. Gary Lipe, of Quantico, Va.; and his mother, Mrs. Carrie H. Allen, of Milton.

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is the preferred vehicle of choice because of its ease of administration and its lasting effect. Complete literature on request.

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coronary vasodilator

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for **Sustained** *coronary vasodilation and protection against anginal attack*

SUBLINGUAL

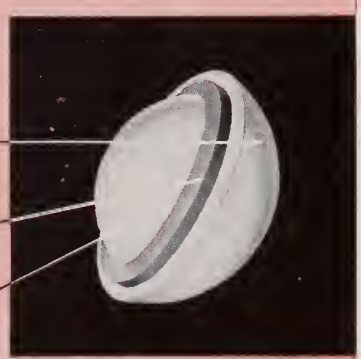
for **Immediate** *relief from anginal pain*

DILCORON contains two highly efficient vasodilators in a unique core-and-jacket tablet.

Glyceryl trinitrate (nitroglycerin)—0.4 mg. (1/150 grain) is in the outer jacket—held under the tongue until the citrus flavor disappears; provides rapid relief in acute or anticipated attack.

The middle layer of the tablet is the citrus "flavor-timer."

Pentaerythritol tetranitrate—15 mg. (1/4 grain) is in the inner core—swallowed for slow enteric absorption and lasting protection.

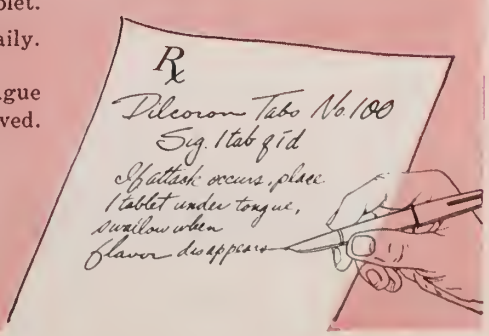


Bottles of 100.

For continuing prophylaxis patients may swallow the entire Dilcoron tablet.

Average prophylactic dose: 1 tablet four times daily.

Therapeutic dose: 1 tablet held under the tongue until citrus flavor disappears, then swallowed.



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Theodore McKee Trousdale

Dr. Theodore McKee Trousdale died at his home in Sarasota on April 16, 1957. He was 58 years of age. Interment took place in Rome, Pa.

Dr. Trousdale was a native of Platteville, Wis., where he was born in 1898. He was graduated from Cornell University in 1921. He received his medical degree from the Johns Hopkins University School of Medicine in 1925 and completed his postgraduate training at Long Island Hospital in 1931.

Locating first in Peaksville, N. Y., Dr. Trousdale engaged in the practice of medicine there until his entry into World War II. He served four and one-half years in the Army Medical Corps. After his separation from military service, he came to Florida and made his home in Sarasota. For 11 years he practiced his specialty of ophthalmology and otolaryngology there. Locally, he was a member of the Sarasota American Legion Post, and he was affiliated with the First Methodist Church.

Dr. Trousdale was a member of the Sarasota County Medical Society and the Florida Medical Association. He also held membership in the American Medical Association and in his specialty societies.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Wade S. Rizk, of Jacksonville, announce the birth of a daughter, Katherine Wade, on October 1, 1957.

Dr. and Mrs. William J. Phelan, of Jacksonville, announce the birth of a daughter, Colleen Teresa, on October 22, 1957.

Deaths — Members

Neill, Robert G., Orlando	October 19, 1957
Tolar, Julian N., Sanford	October 23, 1957
Brooks, Warren A., Winter Park	November 9, 1957

Deaths — Other Doctors

Burns, Joseph P., Lake City	October 28, 1957
Carroll, Charles H., Miami	November 10, 1957
Stormont, Riley M., Webb City, Mo.	July 24, 1957

Eighty-Fourth Annual Meeting
Florida Medical Association
Hotel Americana, Miami Beach
May 10-14, 1958

When anxiety and tension "erupts" in the G. I. tract...

IN DUODENAL ULCER



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Nicotinic Acid.....50 mg.

1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954



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MRS. WILLARD L. FITZGERALD, Treasurer.....*Miami*

Doctor's Day Awards

It looked like a wide Florida beach, the white sand strewn with driftwood and seashells gleaming in the sun. Only this was different — it was the cloths as white as the sand and the wood grayed and weathered on the tables. The driftwood was abloom with orchids, white, lavender, and royal purple, and it was the Blue Room of the Delano Hotel at Miami Beach.

The annual Doctor's Day Awards luncheon of the Woman's Auxiliary to the Southern Medical Association, given in honor of our doctors, had as its theme this year "Orchids to our Doctors," and each person had an orchid to take away from the luncheon, carefully kept fresh in a small container of water.

The exclamations at the beauty of the decorations kept resounding like the surf on the beach as more and more Southern doctors and their wives entered the room. Is it any wonder Southern has been here four times and will be returning in 1962. We will welcome them again as before, being well repaid with compliments during the meeting, and the letters and notes which continue to arrive recalling the "wonderful time we had at Southern in Florida, you were so friendly and hospitable."

Doctor's Day is observed on March 30, the anniversary of the day in 1842 when sulphuric acid ether was first used in a surgical operation by Dr. Crawford W. Long of Georgia. Begun in 1933 in two Georgia county Auxiliaries, its was shortly thereafter adopted by the Southern Auxiliary and is now part of the program of the Auxiliary to the A.M.A. It is the day on which we of the Auxiliary honor our physicians in many and varied ways, suiting the means to our own communities. It is also the day on which, if possible, we try to provide some personal pleasure for our hard working husbands with dinners, barbecues, dances or other entertainment.

The awards given at the Doctor's Day Awards luncheon are for the most original, outstanding and unique observance of Doctor's Day the past

(Continued on page 773)



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what are the differences among tranquilizers ?

Reviews of ataraxic therapy commonly divide the available tranquilizers into three main categories: the rauwolfia derivatives; the phenothiazine compounds; and a smaller group of agents which are lumped together for the sake of convenience rather than because of any common characteristic.

As a result, one significant fact is often overlooked: ATARAX (hydroxyzine) does not fit into any of these three categories. Indeed, by any logical criterion, it belongs in a class by itself.

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*Documentation on request

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for adult tension and anxiety
25 mg. tablets—one tablet q.i.d. Syrup—one tbsp. q.i.d.

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100 mg. tablets—one tablet t.i.d.

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Parenteral Solution—25-50 mg. (1-2 cc.) Intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

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Medical Director

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(Continued from page 770)

March. One award goes to the state having the best statewide observance, one to the county of more than 50 members, one to the county of less than 50 members and an honorable mention in each category. There is also the Feldner Trophy which is awarded to the state for its county auxiliary submitting the best total observance, regardless of size.

There was a round of applause when Seminole county, with 14 members, won honorable mention in the small county group for the second successive year; there was louder applause when Florida Auxiliary was presented with a crisp ten dollar bill for the best statewide observance and then the roof was raised when Florida was presented the Feldner Trophy, for the observance of Dade County Auxiliary. Mrs. William P. Smith, President of Dade County Auxiliary and General Chairman of the Southern Convention, and Mrs. Maurice Greenfield, President-elect of Dade County Auxiliary, had been the Co-chairman for this observance. Mrs. Robert F. Dickey, Dade Auxiliary's President in March 1957, Mrs. Robert F. Mikell, who had written the original skit, and all the Dade County Auxiliary members who had worked so hard were there to receive this honor. The only drawback was that Mrs. Leffie M. Carlton Jr., of Tampa, and Mrs. Scottie J. Wilson, of Ft. Lauderdale, Chairman and President respectively last year, were not present to accept the state award. It was the excellence of the county observances in each of the 24 counties and Mrs. Carlton's skill in reporting them which was the determining factor in our winning the prizes.

So when the Auxiliary in your county has its Doctor's Day celebration, forget the office and the hospital for this one night and join in the fun with the other doctors in your society. Laugh at the skit or the songs which poke gentle fun at you; dance if you aren't too tired or the music isn't too fast and remember the Auxiliary is trying to show its pride in your chosen profession and to provide some moments of fun and relaxation, where the burdens of your profession can be set aside, to be resumed with renewed vigor from the night's respite.

Mrs. Perry D. Melvin

The Thirty-First Annual Meeting of the Woman's Auxiliary to the Florida Medical Association will be held in May at the Hotel Americana, Bal Harbour, Miami Beach.

when anxiety and tension "erupts" in the G. I. tract...

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BOOKS RECEIVED

It Pays to Be Healthy. *A World-Renowned Physician Guides You to Success, Happiness, and Health in Your Work.* By Robert Collier Page, M.D., F.A.C.P. Pp. 285. Price, $4.95. Englewood Cliffs, N. J., Prentice-Hall, Inc., 1957.

Reminding the reader that the tensions and frustrations of his job can take years off his life unless he knows how to handle this vastly important area of his daily living, this book shows him how to analyze his job and his approach to his job, how to deal with people who may annoy him, how to find the job that is right for him, how to know himself as he really is. In short, he learns how to meet the competition he must meet, earn more money as he goes along, and keep himself healthy, likeable and energetic.

As a medical consultant for management, the author has studied employed persons as whole persons who have likes and dislikes, who go home to families, who rear children, who want some of the good things that money can buy. In this book he helps one understand the stages of life through which all must pass, and the special problems of each stage. He gives careful, friendly counsel to the wife of the ambitious man. He shows how attitudes, secret thoughts and personality can make or break one. He also makes clear a few simple, safe technics--not medicines—that can help anyone lead a better life, no matter what his job may be. In addition, he shows how executives really get results from their staffs, how industry really looks at the worker, and the meaning of authority. There are surprising revelations about the worker and about American business in this frank, comprehensive book. The reader will be rewarded by finding a fresh approach to his job that offers him the greatest possible reward and shows him how he holds in his hands the key to health in everything he does.

From Sterility to Fertility. *A Guide to the Causes and Cure of Childlessness.* By Elliot E. Philipp, M.D., M.B., B.Chir., F.R.C.S., M.R.C.O.G. Pp. 120. Price, $4.75. New York, Philosophical Library, Publishers, 1957.

This book was written by a consultant gynecologist and obstetrician attached to a general hospital with a large gynecologic and maternity department to help childless couples decide what can be done to overcome their infertility. About one in every six couples is childless, and undoubtedly some of these millions can be assisted by doctors who give advice, conduct investigations to find the causes in individual cases, and treat the causes when they are discovered and are amenable. The book does not and cannot replace the doctor, but it will save doctors and patients precious hours by explaining for the lay public some of the known reasons for infertility and how and why the investigations and treatments are carried out. Helpful diagrams and charts are included, and advice is given concerning the adoption of babies through the registered societies and authorities.

The Chronically Ill. By Joseph Fox, Ph.D. Pp. 229. Price, $3.95. New York, Philosophical Library, Inc., 1957.

This book attempts to survey some of the facets of what has become a most significant demographic and public health problem confronting the nation. This sociologic approach to the problem should be of great interest to the busy physician, the social worker, the hospital administrator and those in labor and management who deal with the chronically ill. The approach is first to consider chronic disorders as they strike the individual, and only after they have been discussed in that setting are the problems of organization, institutionalization, finance and ethics discussed. The author, who has had wide experience as administrator of a home for aged and of a small chronic disease hospital, has devoted almost two decades to the study and analysis of the long term patient and the aged.

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Management of the Patient With Headache. By Perry S. MacNeal, M.D., F.A.C.P., Bernard J. Alpers, M.D., Sc.D. (Med), F.A.C.P., and William R. O'Brien, M.D., F.A.P.A. Pp. 145. Price, $3.50. Philadelphia, Lea & Febiger, 1957.

Probably no other symptom has such hidden meanings as headache. In this book, the authors provide a basic, clinical understanding of the problem and discuss causes, differential diagnosis and treatment of the several types of headache. Medical, psychologic and neurologic factors are considered fully in their relation to causes and to therapeutic management. Emphasis is on treatment of the patient and the many problems involved, as well as on the headache itself. The authors stress the need for —and tell how to obtain—a detailed history of the symptom, a sound estimate of the patient's personality, and a knowledge of the social history, previous adjustments, emotional stability, and other factors which provide the basis for a personality study. Discussions of the psychologic and vascular mechanisms of head pain precede a sound consideration of headache as a symptom of hypertension and other cardiovascular disorders.

Differential diagnosis and treatment are covered from every phase of the subject. Under Headache in Organic Brain Disease, are discussions of brain tumors and abscesses, meningitis, vascular lesions, cough headache, subdural hematoma, subarachnoid hemorrhage, post-traumatic headache, and cerebral aneurysms. Other forms given equal attention are tension, psychogenic, migraine, allergic, hypertensive, premenstrual, menopausal, arteriosclerotic, and allergic and histamine headaches. Ocular factors, paranasal sinuses, the neuralgias and other extracranial causes are taken up separately.

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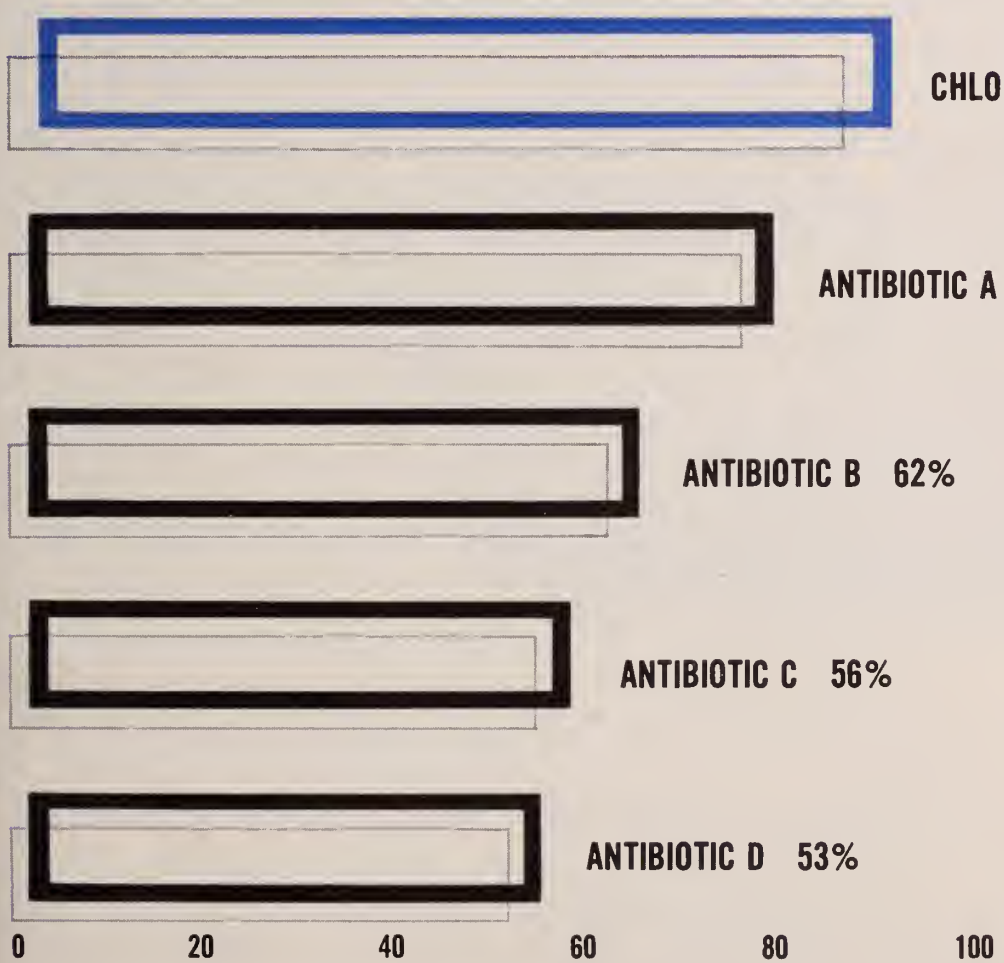
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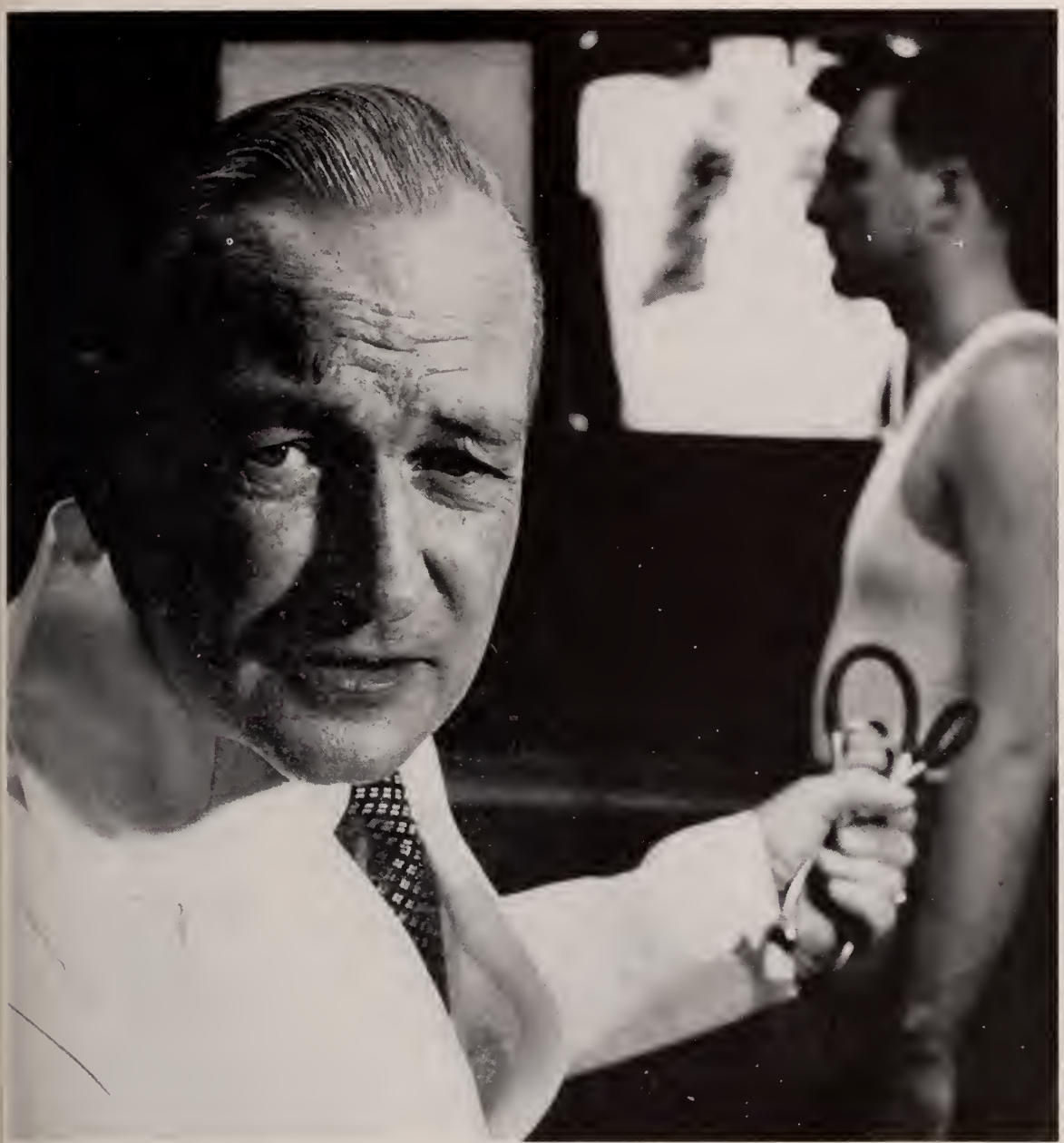
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Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924



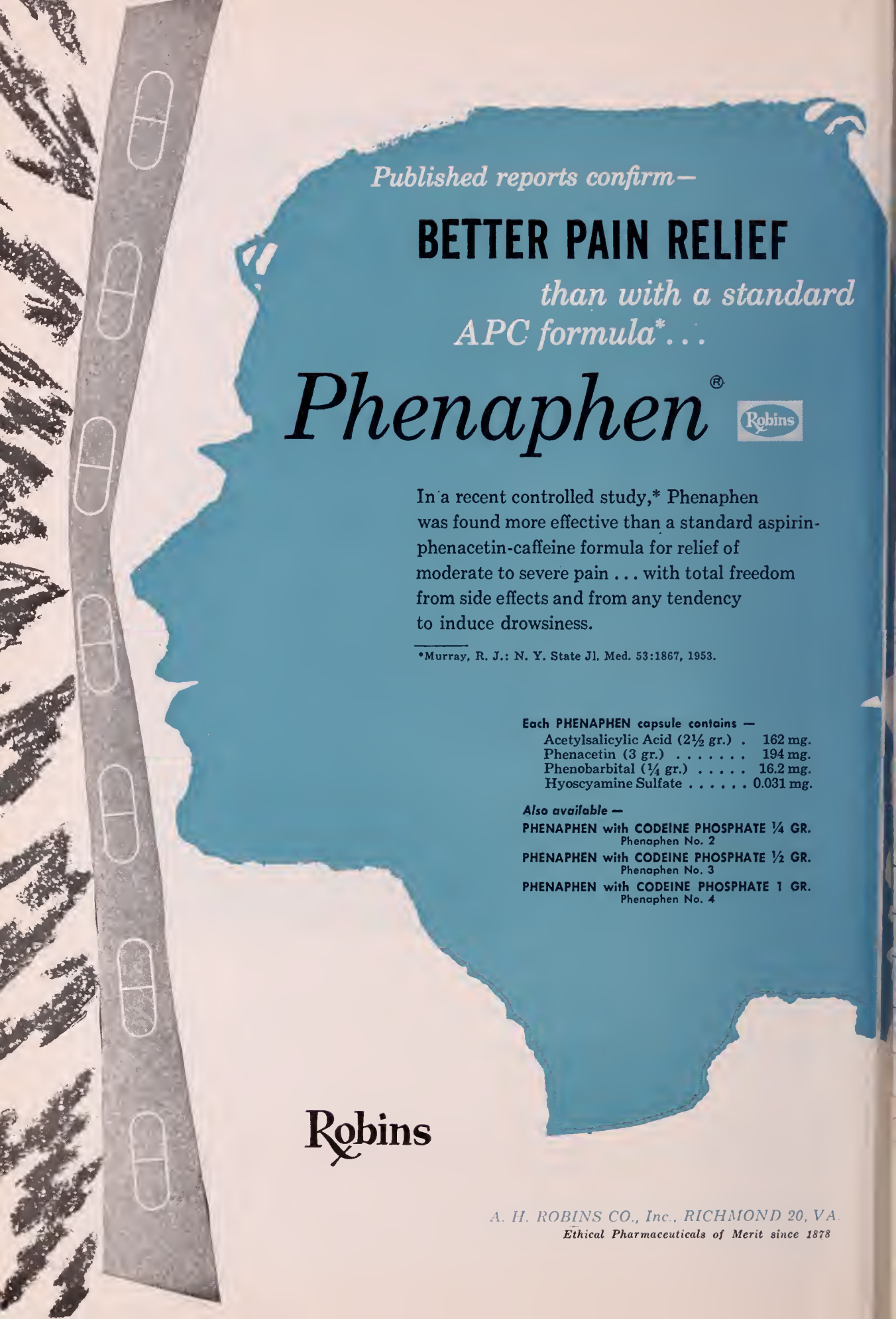
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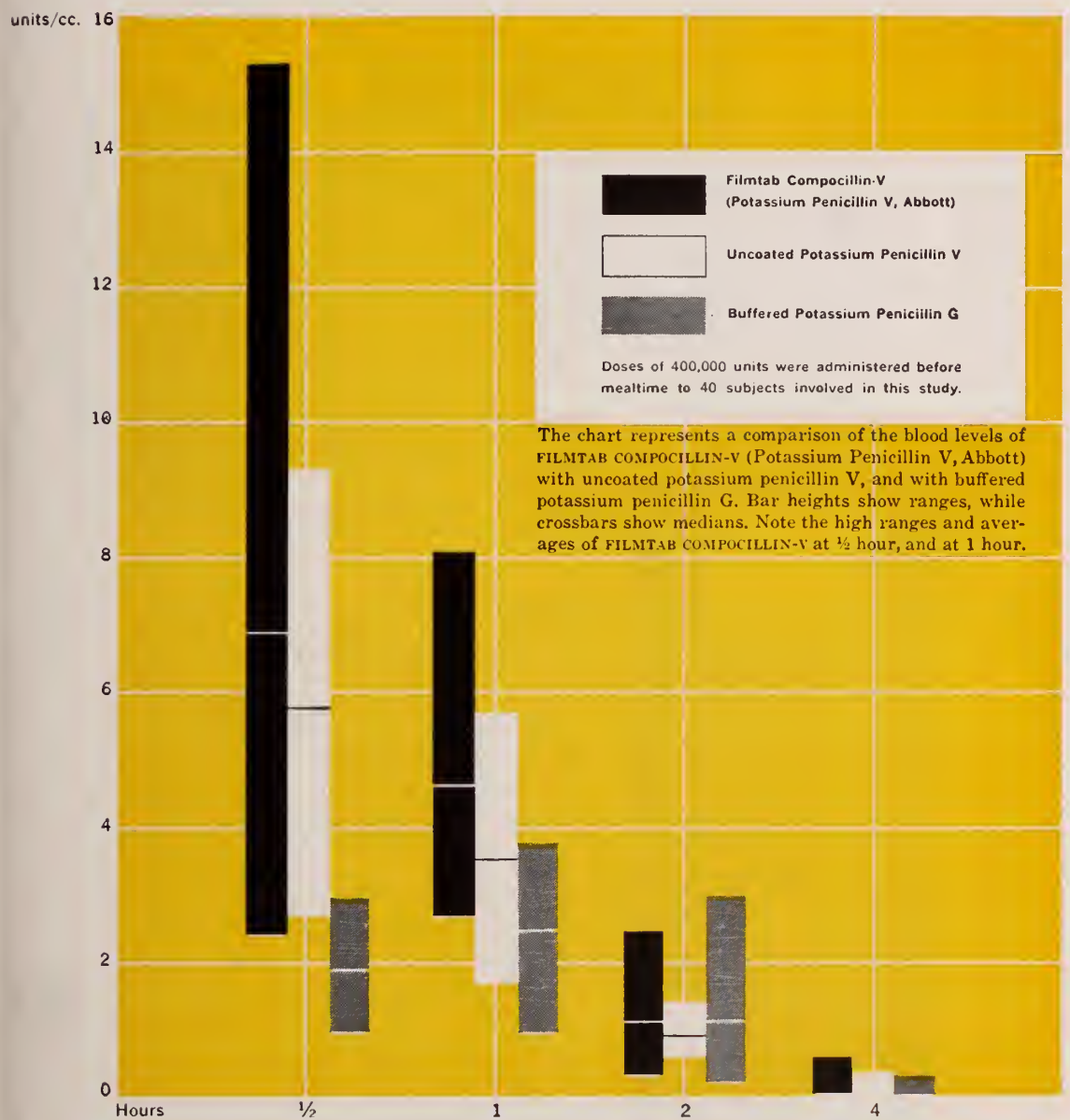
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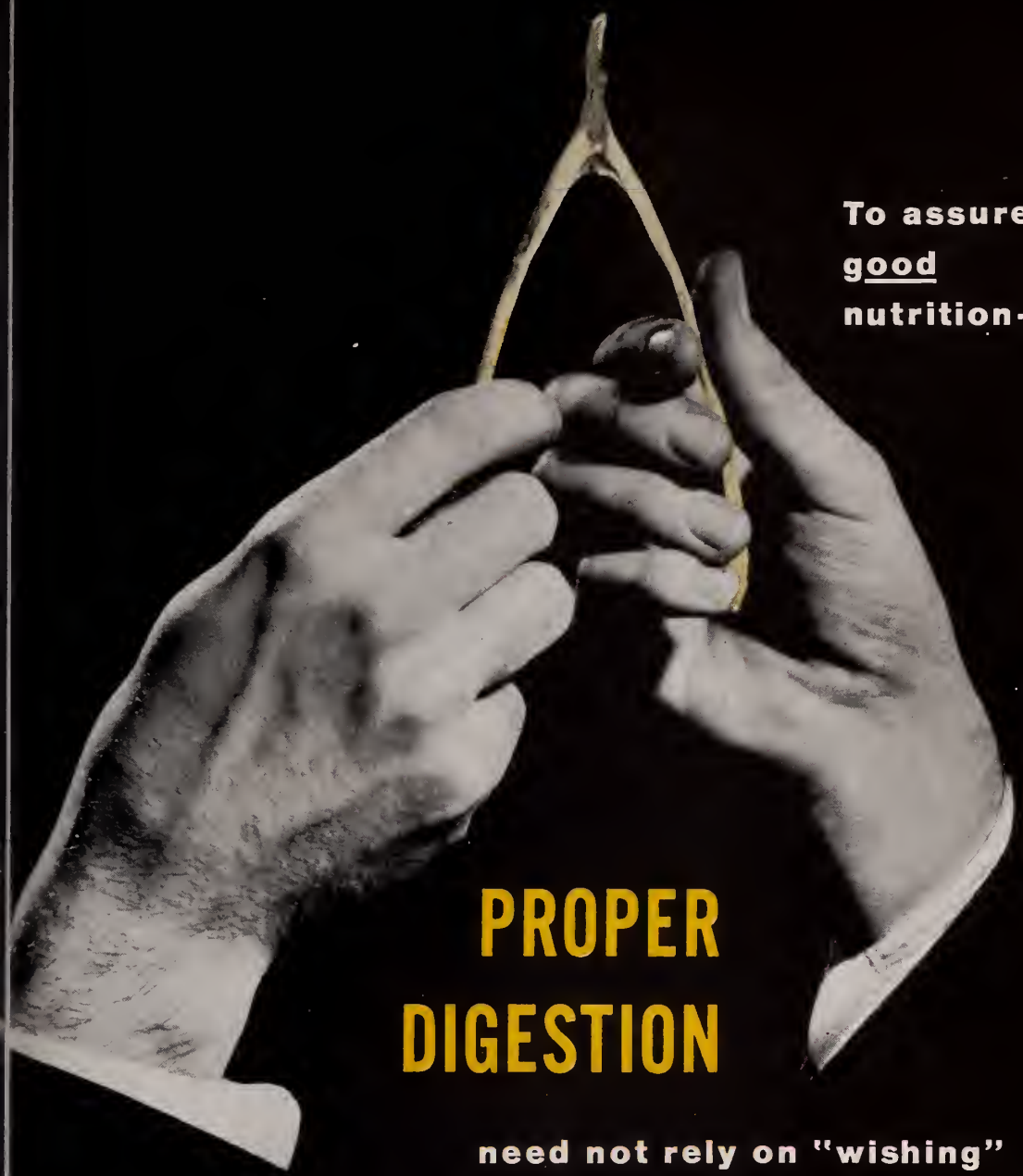


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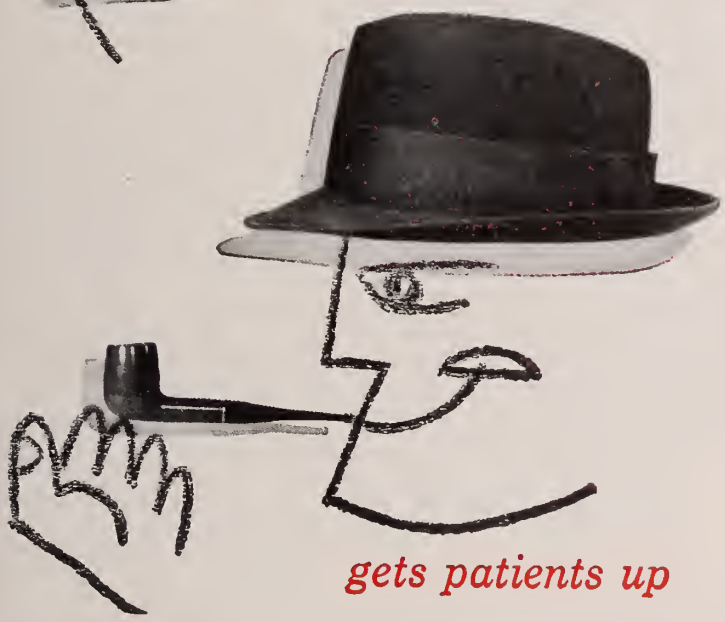
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The Journal of The Florida Medical Association
PUBLISHED MONTHLY

Volume XLIV | Jacksonville, Florida, February, 1958 | No. 8

Transplantation of the Ureters Into an Isolated Ileal Loop

J. Harold Newman, M.D.
JACKSONVILLE

In certain diseases it is necessary or desirable to divert the urinary stream above the level of the bladder. This operation has extremely serious implications for the patient, and while many procedures have been described, no entirely satisfactory method has been worked out. Transplantation of the ureters into an isolated segment of ileum appears to offer major advantages over previously used methods.

The simplest means of urinary diversion are nephrostomy and cutaneous ureterostomy. Both of these operations have disadvantages which limit their scope. In nephrostomy, a catheter is necessary, which must be periodically changed. Infection and calculus formation are common. With bilateral nephrostomy, there are two widely separated openings, making their care a real chore. In cutaneous ureterostomy, two openings are also necessary, but they are closer together and more conveniently located. The major drawback to cutaneous ureterostomy has been the frequency of serious complications with the ureteral stoma. Up to this time, ureterosigmoidostomy has been the most widely used method of urinary diversion. It has the advantages that urinary and fecal control are retained and no external collecting appliance is necessary. Unfortunately, follow-up studies show that patients with ureterosigmoid anastomoses do not fare well.[1,2] There often develop severe and progressive pyelonephritis and renal damage as well as certain electrolyte disturbances.[3] Efforts to improve the operation and lessen these complications have led to a better understanding of their mechanisms, but have not done too much to reduce their frequency because the complications are inherent in the operation itself.[4] Pyelonephritis and renal damage occur because the colon is loaded with bacteria which may reach the kidney either via the lymphatics or by direct regurgitation because of high intraluminal pressures developed during defecation. Electrolyte disturbances occur because of reabsorption while urine is being retained in the colon.

As knowledge of the causes of failure of ureterocolic anastomosis developed, new procedures were devised to overcome these shortcomings. Basically, they have all followed the same pattern. Instead of transplantation of the ureters into the intact colon, they were placed into isolated segments of either the large or small bowel.[5,6] The advantages were that an isolated segment of bowel could be rendered sterile, the area from which reabsorption could occur would be smaller, and intraluminal pressures would be nil or much lower. Of the various new operations proposed, Bricker's procedure[7] has attained the greatest popularity (fig. 1). Bricker isolates a loop of ileum and anastomoses the ureters to the loop after closing the proximal end. The distal end is brought out through the abdominal wall as an ileostomy. There are many advantages to this operation. The ileal loop is short and isoperistaltic, and acts only as a conduit so that urine does not remain long enough to permit reabsorption. Intraluminal pressures are low, and regurgitation does not occur even with the open mucosa to mucosa Cordonnier type of anastomosis. The ileum is relatively sterile and may be rendered sterile postoperatively. There is only a single external opening, which is in a convenient location for the patient. At operation, the anastomoses are performed at skin level, permitting more accurate approximation of the ureter to the ileum. The great disadvantage is that an external urine-collecting appliance must be worn.

Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 7, 1957.

Indications

The most frequent indication for ureteroileal anastomosis is malignant disease in which the bladder alone or together with other pelvic viscera must be extirpated. Less frequently, urinary diversion is indicated when the bladder is unable to retain urine either because of contraction, inoperable carcinoma, or fistula which cannot be corrected. It is also indicated in cases of ureteral obstruction which are not amenable to local correction. It has been used in neurogenic vesical and ureteral dysfunction and it may provide the answer to some of the difficult problems when the bladder and ureter are unable to expel or propel their contents.[5] It is probably the procedure of choice in exstrophy of the bladder when pyelonephritis and renal damage have occurred. Ureteroileostomy has been successfully used in cases in which ureterosigmoidostomy was previously performed and the patients are having trouble with pyelonephritis or electrolyte disturbances.

The preparation of the patient is the same as for any other elective small bowel surgery. Violent purgation is not necessary as the ileal contents are liquid and may easily be milked out of the segment to be used. Neomycin alone and in combination with other antibiotics was used in the series of cases reported herein. The surgical technic of the operation has been described by Bricker[7] and will not be given here.

Complications

The morbidity, mortality, and complications of ureteroileal anastomosis are difficult to assess as this operation is often combined with other surgery and the patients frequently have malignant disease which may not be brought under control. There were no operative deaths in the present series of five cases, and Bricker had no operative mortality in 25 cases when ileal bladder substitution was performed without associated pelvic surgery. In Bricker's series of over 100 cases, hydronephrosis occurred in 15 per cent when the pyelogram had been normal initially.[9] It regressed in many cases in which it was present in the beginning. In two cases in my series, pyelograms initially normal have continued to be normal. In one case, the pronounced bilateral hydronephrosis has shown improvement. Although there was an initially normal pyelogram in one case, severe hydronephrosis on the left side developed which required nephrectomy. The other kidney continues to have a normal pyelogram. In one case, a mild hydronephrosis developed on the initially normal left side, but regression of severe hydronephrosis occurred on the right side.



Fig. 1.—An ileal segment is isolated from the main alimentary stream. Following closure of the proximal end, the ureters are anastomosed to the ileal segment while the distal end is brought through the abdominal wall as an ileostomy.



Fig. 2. Case 1.—Preoperatively, there was a normal kidney on the left side and severe hydronephrosis on the right side.



Fig. 3. Case 1.—Postoperatively, there has been considerable improvement on the right side while mild left hydronephrosis has developed.

Bricker reported pyelonephritis in 15 per cent of his cases. He stated that it has been easily controlled with medication. In the present series, pyelonephritis requiring medication developed in only one case. The single patient who has died succumbed from urosepsis 17 months after operation due to the formation of urinary calculi. Hyperchloremic acidosis and other acid base disturbances did not occur in Bricker's series and did not occur in this series. In several cases there was abdominal cramping in the postoperative period, but obstruction requiring reoperation developed in none. In one case, dermatitis developed, probably on an allergic basis, where the bag was attached to the skin. This was corrected by removing the bag and using a catheter in the ileostomy until the dermatitis healed. Since that time, the patient has worn elastoplast between the skin and the bag, and there has been no further trouble.

Reaction of Patients

The patient with the ileal bladder substitution is permanently committed to wearing a bag. Two questions immediately arise. One, how well do the bags work? Two, how do the patients react to them? Fortunately, the answer to both questions is favorable. In this series of cases, the Rutzen and Pierce bags were used. Both are glued to the skin and both have been satisfactory. The Rutzen bag must be made up to size for each patient and cannot be ordered ahead of time. The Pierce bag may be cut to size by the patient or physician and for this reason can be procured in advance and applied to the ileostomy at the end of the operation. The manufacturers of the bags recommend changing daily or twice daily. By a process of trial and error, most patients have found it is satisfactory to change the bag every second or third day. The patient may bathe or shower without loosening the bag.

The reaction of the patients to ileostomy and the bag has been gratifying. These patients have realized that they have a serious problem and all have been willing to accept the necessary inconvenience. The patient with a vesicovaginal fistula, who had been constantly wet, considered ileostomy a decided improvement over her former status. The patients with malignant disease all readily accepted ileostomy when they



Fig. 4. Case 2.—Pyelogram made seven months postoperatively, showing a normal right kidney.



Fig. 5 Case 3.—Pyelogram made five months after operation showing urinary passages of normal morphology and function.

were told it was the best way to take care of them, and so far none have regretted it. The patients have quickly learned to use and take care of the bags. They are able to wear their normal clothing and resume normal activities. There has been no odor problem.

Report of Cases

Case 1.—A 49 year old Negro woman had a large vesicovaginal fistula following radiation for carcinoma of the cervix. This rendered her incontinent, and the tissues about the fistula were such that local correction was not possible. Preoperatively, the left kidney was normal, and the right kidney was severely hydronephrotic (fig. 2). Ureteroileostomy was performed on April 16, 1955. The patient did well postoperatively and quickly learned to use the bag. She was delighted at being dry again. Mild hydronephrosis developed on the left side while the dilatation on the right side regressed (fig. 3). The patient enjoyed good health until July 1956, when she had hematuria and fever. Excretion urography showed nothing new, and the trouble was presumed to be pyelonephritis, for which she received Gantrisin. In September 1956, renal failure and septicemia developed, and she died on September 12. Autopsy disclosed bilateral pyelonephritis due to renal and ureteral calculi. Unfortunately, these calculi were not evident in the pyelograms.

Case 2.—A 51 year old Negro woman was subjected to cystectomy, urethrectomy, hysterectomy and ureteroileostomy on Aug. 7, 1956, for carcinoma of the bladder. The preoperative pyelogram was normal. Following surgery, the pyelogram remained normal for the right side, but there was progressive hydronephrosis on the left side which was treated by nephrectomy on September 15. Since that time the patient has done well except for one episode of pain in the loin on the right side and fever, which responded to Gantrisin. She has adapted herself to the ileostomy and is performing her normal household duties. The pyelogram of April 1, 1957, showed a normal right kidney (fig. 4). Blood chemistry determinations have remained normal.

The hydronephrosis on the left side which occurred in these two cases was probably due to kinking of the ureter when it was drawn upwards behind the sigmoid. In the hope of giving the ureter a better blood supply, only a small opening was made in the mesosigmoid, and dissection of the ureter kept to a minimum. Since that time, a larger opening has been made in the mesosigmoid, and the entire course of the ureter visualized from the retroperitoneum to the ileum. This appears to have solved the problem, and there has been no further difficulty with the left ureter. Care is taken to preserve the adventitia and vessels about the ureter.

Case 3.—A 63 year old white man underwent cystectomy and ureteroileostomy on Sept. 1, 1956, for carcinoma of the bladder. The pyelograms were normal before surgery. Mild hydronephrosis was demonstrated roentgenographically on the eighteenth postoperative day, but the pyelograms have returned to normal (fig. 5). There was no pain in the loin following surgery, and

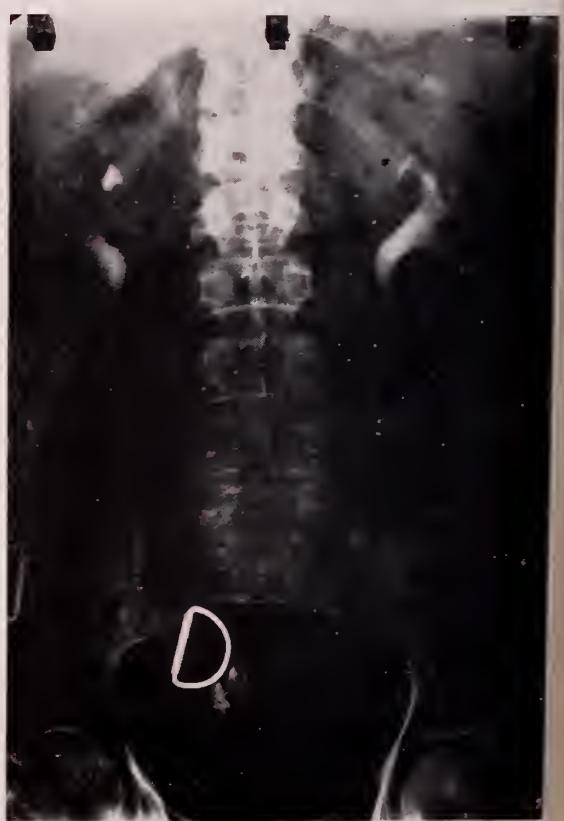


Fig. 6. Case 4.—Pyelogram made six months aft operation showing normal kidneys and ureters.

the blood chemistry determinations have remained normal. The patient quickly learned to use the bag and has resumed his normal activities.

Case 4.—A 57 year old white man was subjected to cystectomy and ureteroileostomy on Oct. 5, 1956, for carcinoma of the bladder. The preoperative excretory urogram was normal. Urograms made on the eleventh postoperative day and again on April 9, 1957, showed normal unobstructed kidneys and ureters (fig. 6). There has been no backache or fever. Blood chemistry determinations have remained normal. The patient manages the bag without difficulty and is able to conduct his normal activities.

Case 5.—In a 67 year old white man with carcinoma of the prostate bilateral hydronephrosis developed due to invasion of the distal ureters by the prostatic growth (fig. 7). The ureters were transplanted to an isolated ileal loop on March 22, 1957. The constant preoperative pain in the loin was relieved. Before surgery, the nonprotein nitrogen was 65 mg. per hundred cubic centimeters. It fell to 38 mg. on the fourth postoperative day. Other blood chemistry determinations have remained normal. Intravenous urography on the thirteenth postoperative day showed more rapid appearance of dye and slight shrinkage of the renal pelves (fig. 8). The patient was discharged on April 6, 1957, and is now at home learning to use the bag.

Summary

A series of five cases is reported in which urinary diversion was accomplished by ureteroileal anastomosis and ileostomy. This appears to be the safest and most satisfactory type of urinary diversion available at the present time. With the possible exception of pyelonephritis, the complications which occur are not inherent in the operation and can be eliminated. External drainage is a disadvantage but not a contraindication. The patients do not feel that they are severely handicapped and quickly adjust to the new method of micturition. They have been able to resume most of their normal activities and lead relatively normal lives. There have been no odor or esthetic problems.



Fig. 7. Case 5.—Preoperative pyelogram showing advanced bilateral hydronephrosis.



Fig. 8. Case 5.—Pyelogram made on thirteenth postoperative day already shows some shrinkage of the renal pelves.

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Discussion

DR. C. BURLING ROESCH, Jacksonville: It is perhaps apropos and quite characteristic that a general surgeon be asked to discuss this fine paper by Dr. Newman, since it has been the impetus of the general surgeon which has brought about a continuing search for an acceptable method to use as a urinary bladder substitution. It would be presumptuous of me to discuss this procedure from personal experience since I have but four cases personally. I have, however, followed Dr. Newman's cases and those of others in our community, and consequently have some familiarity with the problem and this method of the solution of the problem.

Dr. Newman has brought out beautifully the scientific and technical aspects of this operation. I should like to dwell a little on the human aspect of the problem; the art of medicine, if you will, rather than the science of medicine.

In my early years in surgery, I had the good fortune to work under Dr. C. D. Creevy, who was most interested in radical extirpation of the bladder for carcinoma and utilized bilateral cutaneous ureterostomies for urinary diversion. It was from this experience and other contacts with this procedure that I have developed a deep-seated antipathy toward cutaneous ureterostomy and the continuing postoperative complications which this operation, in general, presents. This is particularly true when one has repeated contact with the patient who is having intermittent pyuria with fever and leakage of urine when the catheter plugs, when the patient lies down and there is no siphonage from the ureteral stoma, when granulation constricts the orifice, or when numerous other complications occur, all of which disturb profoundly even those patients who are not of a fastidious nature. Certainly, those patients with tender sensibilities are markedly depressed by the care of a bilateral cutaneous ureterostomy. It is here, I think, that this procedure offers its greatest help.

More and more people are being submitted to more radical extirpative surgery as the result of our continued attack on cancer. Of the 150 operations performed by Bricker and his associates since the inception of this method in 1950, 118 operations were performed for patients undergoing exenteration of the pelvic viscera, and only 32 for those in whom bladder substitution was instituted for other reasons. The rapid adoption of this operation is good testimony to its efficacy. I am surprised that it has not been more generally seized upon by the urologic members of our group, but rather that the general surgeons have pressed for its adoption.

Recently, I attended a reunion at the Cornell University-New York Hospital Medical Center and was surprised to hear the Chief of Urology, Dr. Marshall, state that he had not performed this operation. In the Surgical Department, however, Dr. William Barnes, a classmate of mine, has done so in many cases with great satisfaction, and is even now attempting to develop a water-tight connection to obviate the necessity of epidermal cement.

Patients subjected to this procedure are happy patients. They are relieved of the pain, the constant necessity to void, getting up five, six, a dozen times a night to pass a few drops of urine or to leak constantly through a vaginal fistula. One has but to talk to patients in whom other procedures have been tried, and as a secondary measure have had the ureters placed in the isolated loop to realize what a boon this is to any patient who needs a substitution for the urinary bladder. Even the most uneducated person can be instructed in the simple care of this isolated loop, and thus far, the complications have been minimal in our experience and in that recorded in the literature.

I have certainly enjoyed Dr. Newman's fine presentation and the opportunity to reiterate his recommendation of the procedure for more widespread use.



Clinical Management of Traumatic Hyphemia

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SARASOTA

The management of traumatic hyphemia presents one of the most serious of ophthalmologic problems to the physician. Many eyes have been lost or have suffered serious functional impairment when a seemingly trivial contusion was complicated by late bleeding and secondary glaucoma. That many therapeutic approaches to this problem have been advanced over the years is tacit evidence that as yet no ideal cure has been achieved.

Most hyphemias are small, and the bleeding is transient and spontaneously controlled by an equilibration between vascular and intraocular pressure, and by the contracture of the lacerated vessel. With the more severe hyphemias, however, seen when a vessel of arterial size is damaged, particularly those near the root of the iris, the possibility of secondary hemorrhage occurring on the second to the fifth post-traumatic day is increased. The source of the secondary bleeding is probably from damage to the ciliary body rather than an iris vessel.[1] The slit lamp appearance of the impaired eye often will not reveal the true nature of the injury, but if an iridodialysis is present or a gross rent in the iris, then one should be more expectant of complications. Secondary hemorrhage is more common in adults than in children. Secondary hemorrhages also tend to be more profuse than the primary bleeding. Absorption of the blood takes place mainly from the anterior surface of the iris, and most uncomplicated hyphemias will be absorbed in from one to seven days, leaving no trace.

The common early complications of traumatic hyphemia are secondary bleeding, secondary glaucoma and blood staining of the cornea. When the tension rises from secondary hemorrhage, the color of the blood turns from red to almost black. It is because of this appearance that the classical term "eight-ball hemorrhage" has been applied. Long term complications are posterior synechia; heterochromia of the iris, when the iris of the injured eye becomes darker because of hematogenous pigmentation; and more rarely, hemo-ophthalmitis, when breakdown products of blood pigment are noted in the aqueous and chronic degenerative changes spread throughout the globe. This late complication is rather rare, but, when present, often leads to a chronic, irritable eye, ending in a sightless, hard, painful globe requiring removal. By far the most common and the most serious of these complications is secondary glaucoma.

Read before the Florida Society of Opthalmology and Otolaryngology, Seventeenth Annual Meeting, Miami Beach, May 13, 1956.

Observations in Ten Cases of Hyphemia

Ten cases of hyphemia have been studied. While this series is far too small for valid statistical analysis, some interesting observations may be noted.

Table 1 indicates the pertinent clinical data of the 10 cases studied to show age, agent that caused the damage, visual acuity of the patient when first seen and at the time of discharge, complications, associated ocular lesions, and the day on which the hyphemia finally cleared from the anterior chamber. This table further suggests that the poorest visual results occurred in cases that were complicated with secondary bleeding accompanied by glaucoma. This finding is in keeping with the observations of other investigators.

It will be noted that in four cases there were serious complications, not inclusive of the associated ocular lesions. All cases were managed by the methods outlined herein. The uncomplicated cases need no further mention. The cases in which complications required additional therapy are discussed.

Case 3 was that of an eight year old Negro boy who had been struck in the eye with a baseball bat. He was not seen until eight days after the injury and stated that the eye had become acutely painful two days after the injury and had remained so. Atropine drops had been instilled shortly after the injury, and the child remained ambulatory. When first examined, the eye was hard and the anterior chamber entirely black with hemorrhage. The anterior chamber was opened on the eighth day after the injury, and the clot was removed with a forceps. The pupil was found to be widely dilated and ad-

Table 1. — Summary of Ten Cases of Hyphemia

CASE	AGE	EYE	OBJECT	VISUAL ACUITY INITIAL	VISUAL ACUITY FINAL	COMPLICATIONS	ASSOCIATED LESION	HYPHEMIA CLEARED
1	5	OS	Pea shooter bean	Too Young	Too Young	None	Macular scar	5 days
2	8	OD	Belt buckle	6/15	6/9	None	None	2 days
3	8	OD	Ball bat	No light perception	No light perception	Secondary hemorrhage (2nd day), secondary glaucoma, optic atrophy, posterior synechia	Optic atrophy, vitreous hemorrhage	8 days (?)
4	9	OS	Sling shot (chinaberry)	6/9	6/9	None	Macular scar	7 days
5	13	OS	Hand	6/12	6/6	None	None	2 days
6	14	OD	BB shot	6/60	6/9+	None	BB shot in upper lid without scar	2 days
7	17	OD	Garden hose	CF	6/5	Secondary glaucoma (3rd day)	None	5 days
8	25	OD	Catcher's mask	6/21	6/6	None	Macular edema without scar	2 days
9	32	OS	Wood from power saw	6/60	6/9	Secondary hemorrhage (3rd & 4th day)	Iridodialysis, vitreous hemorrhage	7 days
10	41	OS	Snaffle from fishing line	Light perception	6/60	Posterior synechia, secondary glaucoma, secondary hemorrhage (3rd day)	Iris tear	16 days

herent in that position. Air was instilled into the anterior chamber, and no further bleeding was encountered after the surgery. The pupil has at no time responded to miotics. There was a dense vitreous hemorrhage, which has cleared over the course of eight months. Optic atrophy is now present. The intraocular tension is now normal. The eye is painless but blind.

In case 7, a severe secondary glaucoma developed on the third post-traumatic day, unaccompanied by a secondary hemorrhage. The glaucoma responded in four hours to intensive miotic therapy of Mecholyl and Prostigmine combined with Diamox, and remained controlled on Diamox alone. The eye effected an otherwise uneventful recovery by the fifth day after the injury without surgical intervention.

In case 9, in which there was a severe iridodialysis along with hyphemia, an episode of acute pain occurred in the eye on the third day, accompanied by secondary hemorrhage. The hemorrhage, however, did not fill the anterior chamber. Two to 3 mm. of iris was visible superiorly at all times. There was no increase in intraocular tension. Slight additional bleeding occurred on the fourth day, but there was complete clearing of the chamber by the seventh day. There was no surgical intervention.

In case 10, a tear in the iris was present near the pupillary border, and a severe secondary hemorrhage on the third post-traumatic day filled the anterior chamber with blood. This was accompanied by secondary glaucoma that did not respond to miotics or Diamox. A paracentesis with irrigation was performed 10 hours after the secondary hemorrhage occurred. A large amount of black fluid blood and several clots were removed. Air was instilled, and the patient was returned to bed rest. Slow oozing continued from the area of the iris tear, but at no time was the anterior chamber filled with blood following surgery. Tension remained slightly elevated for 10 post-operative days. By the twelfth postoperative day, the chamber had cleared, and the tension was normal. The postoperative management was identical to that of the uncomplicated cases in this series except for the addition of Diamox.

Discussion of Treatment

Duke-Elder[2] stated that in most cases of traumatic hyphemia absorption takes place satisfactorily with no treatment other than bed rest, sedation and bandaging. While this is certainly true, I believe it important for the physician to be expectant of complications, at least through the treacherous first five post-traumatic days, and to keep a guarded prognosis. In this series the patients were hospitalized whenever possible and put at complete bed rest. Adequate sedation was given to minimize general bodily activity. Certainly, temporary elevation of the vascular pressure brought about by activity would tend to increase the chance of secondary hemorrhage. Systemic sedation in children was heavy and was continued until adequate inactivity was obtained. The head of the bed was elevated 15 to 20 degrees to promote settling of the blood inferiorly in the anterior chamber. Theoretically, this measure should help prevent posterior synechia unless the fluid level of the blood remains above the pupillary border. A binocular dressing was used on all patients in order to remove the incentive for ocular rotations and to decrease pupillary and ciliary activity by removing the stimuli of light and accommodation. In the very young, however, the fear engendered by binocular patching, in spite of heavy sedation, often led to more thrashing and general activity than when the eye was left unpatched. Sand bags or rolled pillows were used on either side of the head to prevent the patient from turning to a facedown position.

The question of the use of cycloplegics, such as atropine or homatropine, or miotics such as pilocarpine, or the use of no drops to alter the pupillary size gives rise to controversy. Mydriasis, as recommended by Thygeson and Beard,[1] stops all movement of the uveal tract and immobilizes the edge of the laceration. Miosis, as advocated by Rychener,[3] opens the filtration angle and increases the iris surface for absorption of the blood. It also partially immobilizes the edges of the wound, but it will cause some congestion of the uveal tract and theoretically could put the edges of the wound on a pull or stretch, thus promoting bleeding. In this small series, neither miotics nor mydriatics were used, except in case 3, in which atropine had been instilled prior to referral. It is thought that one can partially accomplish immobility of the uveal tract by binocular patching, while still preserving the larger iris absorption surface and a relatively open chamber angle. Certainly, if a mydriatic is thought to be indicated, and I believe that it is not, it should not be atropine but rather homatropine, the action of which can be reversed more easily.

Regarding hot or cold compresses, hot compresses would be contraindicated because of the

possibility of effecting a vasodilatation that might promote secondary bleeding.[1] It is questionable if cold compresses actually are of benefit, and it would seem that the danger of the mild trauma incident to pressing on the eye while applying the compress would more than offset the slight advantage of any vasoconstriction that might be effected.

The benefit of vitamin K for bleeding in patients with normal bleeding, clotting and prothrombin times has never been proved. It is not believed indicated unless there is an abnormality in the prothrombin time. Salicylates, however, tend to depress prothrombin production and should not be used for analgesia in these cases.

Capillary fragility may play a role in secondary hyphemia. New vessels are forming by the first, second or third day after the injury. Theoretically, then, vitamin C should be given prophylactically because of its role in the formation of intracellular cement. Theoretically, also, rutin or Quertine might be of value. Evidence has been presented by Schiller[1] that rutin, in doses of 50 to 75 mg. per kilogram, acts as a strong cutaneous vasoconstrictor.

It is possible, therefore, that the effect of the vitamin P flavonoids on capillary fragility may be related to their ability to constrict minute blood vessels strongly. Quertine has the same physiologic effects as rutin.[5] On this basis, 60 mg. of rutin was given three times a day, along with 300 mg. of vitamin C.

Control studies with carbazochrome (Adrenosem) have failed to demonstrate any effect on diabetic retinopathy, capillary counts or capillary mobilization.[6] No studies of its use in hyphemia have been reported. Peele's studies[7] in posttonsillectomy bleedings, however, suggested there may be some hemostatic activity.

It is probable that no systemic hemostatic agents have any beneficial effect, but since Adrenosem is without harmful side effects, I have elected to use it on an empiric basis in a dosage of 5 mg. three times a day for five days.

Steroids, such as cortisone and ACTH, theoretically will cause a lowering of the clotting time and a delayed absorption time; hence, they are contraindicated. The mechanism of hyphemia is not that of the pathologic process of inflammation and would not be an indication for the steroids.

Streptokinase and streptodornase (Varidase) and their role in the clearing of clots in the anterior chamber have received some enthusiastic reports in the literature.[8] Doses of 15,000 units and over, however, have been shown to produce toxic sequelae in the anterior chamber of rabbits. Further, in the rabbit there is no reported difference between the untreated and the treated eye with tolerated doses of Varidase.[9] These data suggest that in the light of present knowledge Varidase is not indicated in the treatment of hyphemia.

In those cases complicated by secondary bleeding, the prognosis becomes poor. If the intraocular tension rises, but the chamber is not completely filled with blood (that is, there is iris visible), one is justified in a trial of miotics, such as pilocarpine and eserine or Mecholyl and Prostigmine, along with Diamox systemically. When employing Diamox to lower the intraocular tension in these cases, one must consider the possibility that Diamox, by decreasing intraocular fluid formation, may lessen the amount of blood washed out of the chamber per unit of time, and hence could theoretically slow up absorption of the hyphemia. DFP (Floropryl) should not be used because of the pronounced congestion it will cause. If the tension is not controlled within 12 to 24 hours, irreversible blood staining of the cornea may develop. Early surgery is indicated, and I believe 10 hours should be the limit of conservative effort. If the chamber is completely filled with blood and the tension is elevated, conservative measures will probably not be effective, and surgical delay would not seem justified. The eyes that suffer secondary hemorrhage usually have some resultant loss in vision, but often early surgical intervention will prevent loss of the eye.

Simple paracentesis with gentle irrigation, repeated often enough to control intraocular tension until the blood begins to be absorbed, will often suffice to control the secondary hemorrhage. Irrigation should be minimal and it should not attempt to dislodge small tenacious clots on the iris, as to do so may reopen a bleeding vessel. The injection of an air bubble into the anterior chamber at the time of paracentesis will tend to promote clotting.

Wilson and his co-workers[10] advocated the routine use of air injection into the anterior chamber in all cases of traumatic hyphemia as a prophylactic procedure against secondary hemorrhage.

The air bubble acts as a cushion in the event of secondary glaucoma and helps keep the blood from actual contact with the corneal endothe-

lium. If this is to be done in a child, a general anesthetic would be required, and one must weigh carefully the suggested value of the procedure against the dangers of possible postanesthetic excitement or nausea and vomiting with their concomitant increase in intravascular pressure. One must also consider that in order to inject air into the anterior chamber in such cases one must of necessity disturb the balance between the intraocular pressure and intravascular pressure. This disturbance could theoretically initiate secondary bleeding which might not otherwise have occurred. I would, therefore, not elect to use this procedure routinely.

Hopen and Campagna[11] reported some beneficial results with the use of trypsin intramuscularly. The cases of hyphemia reported in their series were postoperative rather than traumatic. Their studies suggested that this enzyme may have a beneficial fibrinolysin-like effect on anterior chamber hemorrhages, and is worthy of further investigation. It was not used in this series.

If there is evidence of continued fresh bleeding at the time of paracentesis that does not cease within five minutes, Hughes[12] and Savory[13] advocated thrombin irrigation of the anterior chamber. Human thrombin is used in a dosage of 5 to 10 units per milliliter. Bovine thrombin should not be used because of the danger of foreign protein reaction.[14] After the clot and the fluid blood are irrigated out, the anterior chamber is gently irrigated with the thrombin mixture for about one minute, until the bleeding vessel has clotted. I have had no firsthand experience with this procedure, but I believe that it is a logical adjunct to our "pharmamentarium" at the time of surgery, and worthy of trial.

If there is a large clot in the anterior chamber, often paracentesis and irrigation will not dislodge or remove it. If allowed to remain, it may lead to posterior synechia formation and possibly even a late iris bombé, especially if the entire pupil is covered. In such cases, the clot may be removed by opening the anterior chamber. A small Graefe knife incision is made at 12 o'clock. A knife is used rather than a keratome to avoid damaging the lens or the iris. This incision can be enlarged with scissors. Postplaced corneoscleral sutures, three to four in number, are put in. The corneal flap is then held up and the clot grasped with a capsule forceps without teeth and removed. Any remaining blood is then irrigated out. The sutures are closed, and an air bubble is instilled. This method has been most satisfactory in the removal of large clots.

Summary and Conclusion

Traumatic hyphemia is an extremely serious ocular condition. There is no general agreement in the literature regarding its management.

Observations are made on a series of 10 cases, and various forms of treatment are discussed.

The cases in this study were managed by the following routine for the first five post-traumatic days, except when complications indicated a change:

(1) Hospitalization at complete bed rest. (2) Sand bags to the side of the head, and the bed elevated 15 to 20 degrees. (3) Adequate sedation to prevent general bodily activity. (4) Rutin, 60 mg., and vitamin C., 300 mg., three times a day. (5) Binocular occlusive patching, unless the patient is too young to make this practical. (6) Adrenosem, 5 mg., three times a day. (7) No drops in the eyes.

If secondary hemorrhage occurs, strong miotics are indicated accompanied by systemic administration of Diamox. If the anterior chamber is completely filled with blood, immediate surgery is indicated.

Paracentesis with gentle irrigation and air instillation is the preferred primary procedure. If this is unsuccessful, corneal section with mechanical removal of the clot may be employed. Thrombin irrigation is worthy of consideration.

After the direct effects of injury have quieted down and the danger of further hemorrhage has passed, the pupil should be dilated and the fundus carefully inspected for evidence of retinal detachment or other residual damage to the fundus.

I am indebted to Dr. Irving H. Leopold for his critical review of this paper before publication.

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Highlights of Second International Congress for Psychiatry

Zurich, Switzerland, Sept. 1-7, 1957

I. Leo Fishbein, M.D.
MIAMI BEACH

After a long interim of seven years since the First International Congress was held in Paris in September 1950, the Second Congress began its serious work in the cultured and friendly climate of cosmopolitan Zurich, which has been, since the Bronze Age, a center for civilized man in the arts and sciences. It remains today a great city devoted to the liberal spirit and welfare of its citizens and attuned to its many visitors from all over the world.

In this cheerful and dedicated atmosphere the Second Congress began its stimulating deliberations. About 3,000 members from 64 countries were there, most of them coming from Europe and the Americas. Every continent was represented, from Iceland to South Africa and from Israel to Australia. Russian colleagues were conspicuous by their absence. Polish, Bulgarian, Czech and Yugoslav psychiatrists were present and active in the seminars.

One hundred and thirty papers were read at the plenary sessions. Forty symposiums, besides section sessions and discussion groups, were incorporated in the proceedings. Five official languages were employed: German, French, English, Spanish and Italian. More than half of the speakers spoke in several of these languages. Some simultaneous translations were available.

Theme and Aims of the Congress

Wisely and judiciously, the Congress chose one main theme, "The Present Status of Our Knowledge About the Group of Schizophrenias." Many organizations and individuals helped in the financial and supportive activities so necessary for such a great international undertaking. Many sponsors shared in the expenses, among them American firms and foundations such as the Aquinas Fund, Schering Corporation, Scottish Rite Masons, Smith, Kline & French Laboratories, Squibb Institute for Medical Research, Wallace Laboratories, Wyeth Laboratories, and Burroughs Wellcome & Co.

Dr. Manfred Bleuler, son of the late esteemed Swiss psychiatrist, Eugene Bleuler, delivered an inspiring and forceful address on the aims and theme of this Congress. He emphasized the great responsibilities psychiatrists have in trying to solve one profound problem of mental illness, schizophrenia. He pointed out that this regressive, destructive process, disintegrating the personality and distorting reality relationships, afflicts one per cent of the human race, respecting neither class, position nor national boundaries; that the etiology, terminology and therapeutic procedures in different areas of the world are still in dispute, because of the magnitude of the problem as well as differences of communication in the various languages. This Congress, he said, needed great courage in absorbing the knowledge and understanding of the bewildering enigma loaded with psychopathologic, physiologic and hereditary intricacies that seem so inaccessible.

Dr. Bleuler deplored the tragic negligence of the treatment of schizophrenic patients of all ages. He lamented society's terror of the malady by wishing it away or condemning the afflicted because they became sick. "Reflect and do not doubt; we are proud to obtain comprehension of this dread disease and a treatment does exist! We are constantly present at their suffering! Our common task is the heroic effort to aid all schiz-

From the Departments of Psychiatry, Jackson Memorial Hospital, Miami, Veterans Administration Mental Hygiene Clinic, Miami, and Mt. Sinai Hospital, Miami Beach.

ophrenics everywhere, not only those in favorable clinics!"

Dr. Bleuler found recompense in sharing the common language of psychiatric colleagues dedicated with determination, audacity and sacrifice to wipe out this scourge of humanity. This Congress was united in rendering understanding and encouragement in the great battles ahead, in mobilizing society to take its full responsibilities toward the mentally ill.

His stirring remarks were profound. "The schizophrenics are like ourselves, with all the human aspirations and hopes! Their poignant experiences need to be shared and evaluated. Their dissociative personalities need to be restored to sanity. We must demand more from society which must not now close its eyes with indifference, ignorance, mockery, or contempt!"

In continuing, he explained that the life history of the schizophrenic is as important in therapy as the detailed study of the family background. Re-education of those associated in the familial setting is imperative. The illness has either an hereditary predisposition on a psychodynamic development of the personality and a specific release situation. It is not enough to provide big institutional buildings and smother the sick by their structural magnitude. The tragic accumulation of events needs to be analyzed and understood, and unfavorable human relationships need to be changed. Metabolic disturbances do not often play an important role in the development of schizophrenia, which manifests a severe alteration of the psyche with depersonalization, dissociation, regression, hallucination and delusions. Resignation about this illness has a demoralizing effect on humanity everywhere. Each human personality is different and needs to be understood. The myriad problems of human growth development and relationships need clarity and equanimity. Integrated research is a must. The newer chemicals are ancillary in the total aspect of restoring the mentally sick to good health and further usefulness as individuals. Finally, he stated, the unanimity of purpose of this Congress transcends boundaries of languages, nations and people. The personality needs a more favorable soil for proper development.

Dr. Jean Delay, of Paris, on behalf of the International Organization of World Congresses for Psychiatry, spoke of the great liberation of the mentally ill which began in the seventeenth and eighteenth centuries and of the great work done by Swiss psychiatrists.

A great leader, himself, in modern French psychiatry and a prominent organizer of the first psychiatric congress in 1950, he praised the memory of Eugene Bleuler and the fruitful work done by various groups in many countries. "Your presence here as men of science, dedicated to human suffering everywhere, with all points of view and new enriched directions, is further evidence of the unified success of this congress." He anticipated for all of us rich memories of Zurich as we had experienced in the Paris meeting.

World Mental Health Year — 1960

Dr. A. Repond of Malenoz, Switzerland, a great devoted friend of world psychiatry and a frequent visitor to Florida and American psychiatric group meetings, was proud to have his native land serve as host to such a distinguished array of psychiatrists gathered in Zurich. He sincerely felt psychiatry had progressed faster in the last 50 years than at any other time in human history. He had a word of caution for those living in a period of elation with new chemical discoveries that were promising much for the mentally ill. He requested that some consideration be given to the inside world of human beings, while the world was going through the geophysical era. He fervently hoped that the psychiatrists, in all countries, would take leading roles to make 1960, the World Mental Health Year, a great success. This fascinating and powerful project, he said, is being sponsored by the World Federation of Mental Health.

Welcome to Switzerland

Dr. W. Konig, Lord Mayor of Zurich, in welcoming the distinguished assemblage in his charmingly official manner, sounded the keynote. "The more that is done, the more there is to be done! My greatest wish is that you help sick human beings become well again!" His city had for many long years accepted the great challenge and responsibilities of its citizens in need of psychiatric help. Everywhere one went in Zurich, there were interesting signs, "Die ruhige Stadt hat weniger Kranke"—"The quiet city has fewer sick people." It could serve as a beacon for all metropolitan centers. Noise, discord, ignorance and poverty were disharmonies civilized man could do without. The Zurich Chamber Orchestra conducted by Edmond deStantz, enhanced the opening session.

Dr. J. Wyrsch of Stans, Switzerland, welcomed the delegates in his excellent Spanish, commenting

that Switzerland had four official languages: German, French, Italian and Romansch. Yet in such a possible Tower of Babel confusion, there were unity and equilibrium in the tremendous tasks to improve psychiatric procedures on an international scope.

Dr. E. Gobbi of Mendrisio, Switzerland, for the organizing committee, welcomed the Italian colleagues in their native tongue, hoping that the delegates would come closer to the comprehension of the dynamics of the psyche and apply them to the benefit of mankind. He declared that Switzerland wanted tourists to come and share the bounties nature had bestowed on his homeland.

In Commemoration

The commemorative session of September 1. 1957, will long be cherished by those who heard the distinguished addresses by Dr. Hans Hoff and Dr. E. Stransky, both of Vienna, Austria. They reminisced about their associations as assistants under the great Julius Wagner Ritter Von Jauregg. His centenary was now being celebrated with that of Eugene Bleuler.

Four distinguished and beloved colleagues, very active in world psychiatry, were given a memorial tribute: Dr. E. Koffsky of Poland, Dr. F. Fromm-Reichman of Washington, D. C., Dr. Braumel of Germany, and Dr. F. Morel of Geneva, Switzerland.

Dr. Hoff, in his erudite scholarly fashion, recalled historical details of the eminent professor and humanist, Von Jauregg. He was one of the first experimenters in general metabolism and thyroid disturbances. In 1835, in Austria, this great physician presented excellent results with thyroid medication in cretinism and myxedema, in spite of the adverse criticisms of his colleagues. He received the Nobel Prize in 1927 for his work in freeing many patients from progressive paralyses with typhoid and malaria fever treatment. His devotion to the sick was phenomenal. "His inner life was vivid and warm. All science to him had one direction, to help all people!"

Dr. Stransky, a young and enthusiastic octogenarian, presented an intimate personal picture of the fascinating Von Jauregg, who was more than a professor. He was an original character, great and spiritual. Von Jauregg looked like a woodcutter, rustic and sportsmanlike. He spoke his languages in brogue. He was tolerant and generous and guided his students and assistants. He was too noble to elevate himself by lowering the prestige of others. He cared little for publicity, preferring to share the goodness for its own rewards and achievements. Even though he differed from Freud about certain views, he gave Freud a professorship at his university. Only recently have his originality and greatness been recognized. "Jauregg will never have a rival! He was one of the last, and we shall never see the like!" The spirit of Jauregg is fully embodied in rich fragrance and warm devotion in these two distinguished orators who have presented ein Mensch!

Dr. Klaesi presented Eugene Bleuler as a man who had a remarkable attitude and admiration for working with sick people. He had respect for all and was always ready to learn something from everyone, from the simple to the profound. He was never fully satisfied, sought the truth in all matters and avoided partisanship. He culled ideas constantly on little cards, any time of the day or night. "He was a great teacher and educator and was fully aware of all the enigmas of his time." His distinguished son, Manfred Bleuler, of Zurich, is endeared to world psychiatry in the revered footsteps of his illustrious father. It is a proud heritage of devoted service to humanity.

Three distinguished colleagues, J. Delay, H. Ey of Paris, and O. Diethelm of New York, were presented honorary degrees of Doctor Honoris Causa by Dean Rossier of the Zurich University Faculty of Medicine for their prodigious efforts in organizing and handling the affairs of the first Congress in Paris. The assembled members warmly applauded such a gracious honor given to psychiatry by our host city.

Dr. Ludwig Binswanger of Kreuzlingen, Switzerland, discussed existential analytic interpretation with special reference to schizophrenia and its victims. He reminded his colleagues that these sick people had misguided ideals and that they were not able to handle themselves. They lacked the feeling of personal worth; their lives were full of the inadequacies and inabilities to cope with responsibilities inherent in the growth pattern of maturity. His therapy was directed toward guiding the patient back to new roles once again in adapting methods that could efficiently deal with reality without excess anxieties. Man could better learn to understand himself as well as his environment.

Dr. H. C. Ruemke of Utrecht, Holland, gave a clinical differentiation within the group of

schizophrenia. He emphasized the impaired judgment and the reduced mental powers of the sick. He was optimistic about getting these patients well, and felt confident there was no obsolete or secret cure. The intuitive feelings and helpfulness of the psychiatrist could make the difference between success and failure. The hopeful goals lay in clinical psychiatry.

Views of Schizophrenic Treatment

Drs. E. Stroemgren, V. Lunn and T. Vangaard of Denmark presented the varied views of schizophrenic treatment in various clinics involving details of the delicate doctor-patient relationships. They were emphatic about the importance of the doctor's subjective judgment and comprehension about the mentally ill. Introspection of his own reactions in dealing with the difficult emotional manifestations was essential as the needs for gratification, proper object relationships, feelings of identity, and narcissistic proclivities manifested even in the normal. The regressive and often infantile distortions, the withdrawal patterns, the unusual cravings, the hostilities and bitterness—all needed proper evaluation.

Dr. Charles Savage of Bethesda, Maryland, delivered an excellent and stimulating treatise concerning analytic treatment of the schizophrenic. The earlier the patient was seen, the better was the prognosis. Countertransference was a legitimate important area of inquiry in therapy since identification had to be more intense. The therapist would experience the patient's anxiety as his own, perhaps also showing primitive or controlling defenses. Alert observations of every description needed to be evaluated. Unresolved unconscious conflicts of the therapist, his infantile and magic omnipotence, his guilt and sensitivities—all these needed to be handled, in the slow, erratic and often nonapparent progress shown in handling the schizophrenic, toward achieving sufficient ego strength and identity, and giving him the gratifications he probably never had.

Drs. D. W. Abse and J. A. Ewing of Chapel Hill, N. C., presented some of the lessons learned in treating schizophrenics. The patients resisted reality-proving methods since they had become overwhelmed by their own inabilities to cope with reality. Uncovering and interpreting the unconscious motivations gave support and relief to these patients. The distorted object-world became a bit clearer. Repressed instinctual impulses were allowed to flow more freely in socially directed channels. The therapist was the patient's representative of reality, and needed to follow with freedom from anxiety the swinging back and forth of the inner defenses that the patient presented.

Treating Schizophrenic Children

Drs. Mildred Creak of London, England, and Lauretta Bender of New York City shared in the erudite symposium of childhood psychoses. Dr. Bender reiterated it was difficult to make decisions about the maturation of children by two years of age, or perhaps even up to five years of age. Quite often the child might be able to overcome his provocative behavior deviations in these early years. After five it might be a question of acceleration or regression of the developing processes. The difficulty often came in either the normal defective lag seen at all levels or in the general backwardness. "Was the boy dim because he was mad or mad because he was dim?" Was his vulnerability of genetic origin or environmentally produced? Both emphasized that a backward child was not necessarily a regressed child. Hasty explanations could cause untold misery for those intimately associated. Children who had fear of space and object-relationships, rigidity, inappropriate emotional reactions, incoordinations, regressions, severe anxieties, and reluctance to leave each maturation phase for the next needed to be carefully studied for evidences of personality fragmentation and dissociative relationships.

Other Treatment

Various discussants gave their experiences with insulin and convulsive therapy in treating schizophrenic children in their hospitals and clinics. Many emphasized the terrible home environment of these children. Insulin seemed to make many of them more accessible for therapy. Ancillary training methods were so necessary in the total aspect of therapy. The speakers lamented the old refrain, "Leave him alone and he'll grow out of it." Too often such delays have made permanent cripples out of those who could have been restored to full health. Blindness was not only reserved for good parents and well-wishing friends, but often iatrogenic neglect was costly in later years.

Drs. D. E. Cameron and S. K. Praude of Montreal, Canada, presented case material of chronic paranoid schizophrenics who were treated with prolonged chemical sleep, from 30 to 60 days, using chlorpromazine and barbiturates. They were accompanied by extensive use of shock treat-

ments which were gradually reduced as rehabilitation methods were instituted. After the patient was transferred to ambulant service, he was given one shock treatment a week for the first month, and then one a month for the next two years. At this time his progress was reviewed and if good, treatment was ended. During the two year period psychotherapy was continued on a limited relationship basis. If relapses did occur, shock treatments were administered on an ambulant basis. They agreed that results were less favorable for chronic cases than for early cases.

Dr. O. Diethelm of New York City reviewed the course of schizophrenics whose illnesses were followed in and outside of hospitals for 30 years. Some began with an acute paranoid excitement in the form of a panic followed by a hebephrenic picture and terminated in simple deterioration. Others started with depression or catatonic excitement. Clinical observation and psychologic studies indicated the far reaching effect of the monotony of the well regimented hospital life. Deteriorated apathetic schizophrenics responded positively to those who were more socially active.

Dr. C. G. Jung of Kusnacht, Switzerland, presented a paper on schizophrenia emphasizing the disintegration of perception, the compensatory character of pathologic content, the loss of compactness, the distorted relationships, the frequent regression to archaic association forms, the lowering of the conscious threshold and the discontinuity of apperception. He was warmly applauded as an Elder of psychiatry. He looked vigorous at eighty.

Drs. N. S. Kline and J. S. Saunders of Orangeburg, N. Y., indicated that the newer group of pharmaceuticals, the tranquilizers, were being used during the last several years with amazing results in reducing the hospital stay of patients as well as preventing many from coming into the institutions. It was a small but important step in dealing with the problem of almost 750,000 hospitalized mental patients. Sedatives, hypnotics, muscle relaxants, and ataractics of many forms were producing results that needed further research evaluation.

Social Therapy of Schizophrenia

Dr. E. E. Krapf, long an ardent worker for world psychiatry and now with the United Nations Organization in Geneva, Switzerland, demonstrated the social therapy of schizophrenia. The therapeutic goal was either to modify the sick person to a better contact with the world of reality, or to introduce beneficial changes in the family and work environment so that the patient could develop a greater adaptability of usefulness in society. The modification of certain primitive behavior patterns needed further elaboration. Changes in social behavior depended on social experiences. The therapist and the patient constituted always a "society of two." Social behavior changed as social confidence improved. Society could well look into its own mirror and see what could be done to lessen stress and struggle and competition among its groups.

Schizophrenia Among Primitive Peoples

Dr. T. A. Lambo of Abeokuta, Nigeria, made observations of schizophrenia among primitive people who first presented psychoneurotic-psychotic overlays, such as confused episodes, twilight states, affective exaggerations with impotence, sexual aversion and homosexual wish-fantasy dreams. In most primitive cultures latent manifestations were usually overlooked, especially when abnormal behavior was devoid of aggression and antisocial trends. Those patients who were brought to town clinics showed clearcut schizophrenic features.

Dr. L. Mars' paper on schizophrenia in Haiti was received with great interest since Dr. Mars has been studying the problem of ethnopsychiatry for many years in his own country. It was my great privilege in visit him in Port au Prince in 1953 and discuss with him many facets of his research. The peasants who formed 80 per cent of the population showed in their delusions a cultural African content with gods and devils. The urban people evoked the Christian God, electricity, radio and other western civilization elements. Schizophrenia was widespread in the economically and culturally unstable middle class and accounted for one third of all mental illnesses there.

It is impossible to elaborate further upon the other excellent speakers and their illuminating discussions for lack of space. A short historical background of psychiatric progress in the last several hundred years is presented to help reacquaint the reader with the constant march of various medical disciplines in healing the sick.

The guided tour through the Zurich University Medico-Historial Collection, arranged and conducted by a former University of Wisconsin professor, Dr. E. H. Ackerknecht, provided a memor-

able afternoon. It was interesting to learn that a Zurich general practitioner, Dr. G. A. Wehrle, had, as a hobby, collected medical curiosities all his life. The University of Zurich purchased his collection in 1932 and housed it in the Tower of the University where it was now seen by the delegates with warm enthusiasm. In 1951, the Institute for Medical History was established in Zurich. This collection was unique for the German part of Europe and similar collections could be seen in London and Copenhagen. I am indebted to Dr. Ackerknecht and his able staff for much of the historical material reviewed.

History of World Psychiatric Progress

1. Celsus, Aretaeus and Soranus wrote extensively of psychiatric disorders in Latin.
2. Jan Wier, Paracelsus and Felix Platter began the renaissance of psychiatry in the sixteenth century, attacking the witch delusions of the Middle Ages.
3. Sydenham and Willis wrote mostly in the field of neuroses hysteria in the seventeenth century.
4. Prefect and Benjamin Rush influenced the philosophy of enlightenment of the mentally ill in the eighteenth century. Others prominent during this period of liberating the insane from their chains were the following distinguished psychiatrists:

 Abraham Joly—Genf, 1787
 Vincenzo Chiarugi—Toskana, 1788
 Philippe Pinel—Paris, 1793
 William Tuke—York, 1796
 Johann Langermann—Bayreuth, 1805
5. The French School, founded by Pinel, dominated treatment in the first half of the nineteenth century. It was continued by his pupils, Ferrus and Esquirol. The pupils of Esquirol — Geroget, Leuret, Falret, Voisin, Foville, Calmeil Baillarger, and Moreau de Tours—all shared in furthering the humanitarian aims of their predecessors.
6. Antoine Laurent Boyle (1799-1858) was the first to describe general paresis as a distinct entity in 1822.
7. Benedict Augustin Morel (1809-1873), a friend of Claude Bernard and a pupil of Falret, was the creator of the influential "degeneration-hypothesis of mental disease" in 1857.
8. Johann Christian Reil (1759-1813) was one of the pioneers in German psychiatry. In the first half of the nineteenth century this psychiatry was divided into the two schools of "psychism" represented by J. Heinroth (1773-1843) and "somaticism" represented by M. Jacobi (1775-1858) Wilhelm Griesinger (1817-1869), of the University of Zurich, received his fame for clinical studies of the somatic and psychologic syntheses in mental illness.
9. Eugene Bleuler (1857-1939), professor of psychiatry from 1897 to 1927, created the term schizophrenia.
10. Karl Ludwig Kohlbaum (1828-1894) and his protagonist, Emil Kraepelin (1856-1926), were pioneers in the modern clinical classification of psychoses. Both showed keen insight into mental diseases.
11. Julius Wagner von Jauregg (1857-1940) opened up a new era of somatic treatments for mental diseases through his malaria fever treatment of general paresis.
12. J. M. Charcot (1825-1893) and H. M. Bernheim (1873-1919) opened up new research studies of neuroses, hysteria, and hypnosis. Pierre Janet (1859-1947) and Sigmund Freud (1856-1936), both strongly influenced by Charcot, were the leaders of the two modern schools of psychotherapy.
13. G. M. Beard (1839-1922) coined the term "neurasthenia" and was one of the foremost students of neurasthenia in the nineteenth century.
14. Joseph Breuer (1842-1925) aided in the creation of psychoanalysis, which will always be associated with the names of Freud, Adler, Jung, Abraham and others intimately associated with this movement.

I look forward with much enthusiasm to the next international psychiatric congress, perhaps in the Americas in 1962. My psychiatric colleagues all over the world will again get together at that time and share in the total experiences of their own lives one common task—to help make mentally sick people well and create a better world for all of us. To this goal, psychiatrists and all men of science must devote their energies and lives in harnessing the good of science to construct a better world and not to destroy it.

420 Lincoln Road.

ABSTRACTS

Molar Sodium Lactate Compared with Electrical Stimulation in Cardiac Arrest. By Leonard M. Silverman, M.D., and Herbert Eichert, M.D. J. A. M. A. 164:1209-1211(July 13) 1957.

A case is reported which presents a unique instance of successful restoration of ventricular rhythm by the use of molar sodium lactate in a patient with ventricular arrest who was being kept alive by means of artificial electrical stimulation. Relatively small doses of molar sodium lactate solution were completely ineffective as a substitute for the artificial pacemaker in maintaining ventricular activity. Large amounts of molar sodium lactate solution, however, were found to be equally good if not better than the artificial pacemaker in maintaining a durable rhythm. General clinical improvement was much more striking with molar sodium lactate solution than with the pacemaker. It would appear that molar sodium lactate may be an adjunct to or may be used instead of electrical stimulation to restore idioventricular beating.

Surgery in Pulmonary Tuberculosis: The Problem of the Poor-Risk Patient. By Nelson H. Kraeft, M.D., and L. Ovelia Linton, M.D. Am. Surgeon 22:1207-1214 (Dec.) 1956.

A significant and increasing number of patients with pulmonary tuberculosis are encountered in whom the application of surgical treatment must often be compromised because of factors which increase the individual surgical risk. Such factors as (1) the increasing incidence of pulmonary tuberculosis in older people, (2) effective chemotherapy which permits survival with extensive disease residua of patients previously doomed, and (3) the significant number of patients with associated but unrelated pathologic processes necessarily indicate groups presenting increased surgical risk. The use in these groups of surgical measures less precise than excision but offering considerable hope of salvage from a precarious balance of chronic invalidism is here discussed.

Experiences with patients presenting poor operative risk in a series of 170 cases are considered. The use of bilateral resection, thoracoplasty with and without cavitary drainage and subcostal plombage in selected cases is discussed. The minimal disturbance of respiratory function in the last group was striking. The results generally were encouraging except in the group treated by subcostal plombage. Since these were mainly salvage procedures, the successes warrant further trial of the procedure in similar patients in the future in the opinion of the authors. They conclude that the problem of the poor risk patient with pulmonary tuberculosis will be solved by earlier recognition of the disease with its occurrence in the older patient kept in mind, by better and continued therapy, and by closer attention to the patient's socioeconomic problems involved by the disease. They conclude further that when pulmonary excision is not deemed feasible, permanent collapse measures are worthy of trial. A prerequisite for success is a patient with reasonably good resistance to the disease and one who will adhere to the therapeutic regimen.

Cutaneous Papillomas of the Neck. PAPILLOMATOUS SEBORRHEIC KERATOSES. By Morris Waisman, M.D. South. M. J. 50:725-732 (June) 1957.

The histopathologic findings in a common skin lesion about which there is varying opinion as to etiology and classification are here described. Clinical and histopathologic features of the common cutaneous papillomas, or tags, of the neck, chest and eyelids are reviewed. The frequent association of seborrheic keratosis and cutaneous papillomas and the suggestive transitions of one form into the other prompt the impression that the papillomas are modified seborrheic keratoses. Histopathologic alterations of small papillomas resemble those of early lesions of seborrheic keratosis. There is a dichotomy of larger cutaneous papillomas into epidermal and fibrous forms, depending upon which tissue element predominates. It is suggested that possibly hormonal factors, such as those attributable to physiologic overactivity of the anterior lobe of the pituitary gland and the adrenal cortex, play a role in this formation.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

House of Delegates

Proceedings of Called Meeting

**George Washington Hotel, Jacksonville,
December 8, 1957**

A called meeting of the House of Delegates of the Florida Medical Association convened in the Ballroom of the George Washington Hotel, Jacksonville, at 9:25 a.m. on Sunday, December 8, 1957, with President William C. Roberts presiding.

Dr. Ralph W. Jack, Chairman of the Credentials Committee, announced that a quorum was present, 95 delegates being registered. (Subsequent report of the Credentials Committee showed 101 delegates registered.)

Delegates

ALACHUA—Henry J. Babers Jr., Walter E. Murphree (*Absent—F. Emory Bell*).
BAY—(*Absent—Harold E. Wager*)
BREVARD—Thomas C. Kenaston, Arthur C. Tedford
BROWARD—Julius F. Boettner, Burns A. Dobbins Jr., Anthony C. Galluccio, John H. Mickley (*Absent—Norris M. Beasley, Richard A. Mills, Paul G. Shell*)
COLLIER—(*Absent—Daniel B. Langley*)
COLUMBIA—Louis G. Landrum
DADE—James L. Anderson, Edward R. Annis, Jack Q. Cleveland, L. Washington Dowlen, James J. Hutson, Ralph W. Jack, Donald F. Marion, John D. Milton, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett Jr., William M. Straight, Jack L. Wright (*Absent—Morris H. Blau, Reuben B. Chrisman Jr., Francis N. Cooke, Vincent P. Corso, Edward W. Cullipher, Robert F. Dickey, M. Jay Flipse, Milton S. Goldman, Maurice M. Greenfield, W. Tracy Haverfield, James W. Holmes, R. Spencer Howell, Joseph T. Jana Jr., Walter C. Jones, David Kirsh, Alfred G. Levin, T. D. Sandberg, Ralph S. Sappenfield, George F. Schmitt Jr., Donald W. Smith, Joseph S. Stewart, Oliver P. Winslow Jr., Corren P. Youmans, Nelson Zivitz*)
DESOTO-HARDEE-
HIGHLANDS-GLADES—(*Absent—Carl J. Larsen*)
DUVAL—Frederick H. Bowen, Hugh A. Carithers, Turner Z. Cason, A. Judson Graves, Karl B. Hanson, Gordon H. Ira, Edward Jelks, F. Gordon King, Raymond H. King, Charles F. McCrory, Richard G. Skinner Jr., John T. Stage, Sidney Stillman, Leo M. Wachtel, Ashbel C. Williams (*Absent — Frank L. Fort*)
ESCAMBIA—Paul F. Baranco, Herbert L. Bryans, Joseph W. Douglas, Gretchen V. Squires (*Absent—Alpheus T. Kennedy*)
FRANKLIN-GULF—John W. Hendrix
HILLSBOROUGH—Samuel H. Adams, William C. Blake, Herschel G. Cole, H. Phillip Hampton, Madison R. Pope (*Absent—Efrain C. Azmitia, C. Frank Chunn, David R. Murphey Jr., James N. Patterson, William M. Rowlett, Wesley W. Wilson*)
INDIAN RIVER—William L. Fitts 3rd
JACKSON-CALHOUN—Grayson C. Snyder
LAKE—George E. Engelhard
LEE-CHARLOTTE-HENDRY—John S. Stewart (*Absent—William H. Grace*)
LEON-GADSDEN-LIBERTY-
WAKULLA-JEFFERSON—Francis T. Holland, Robert H. Mickler, George S. Palmer
MADISON—(*Absent—Wilmer J. Coggins*)
MANATEE—Richard V. Meaney
MARION—Henry L. Harrell, Eugene G. Peek Jr.
MONROE—William R. Ploss
NASSAU—(*Absent—Cecil B. Brewton*)
ORANGE—Frank C. Bone, Chas. J. Collins, Harry H. Ferran, Fred Mathers, Frank J. Pyle, Charles R. Sias, W. Dean Steward, Robert L. Tolle, Miles W. Thomley, Robert E. Zellner
PALM BEACH—Willard F. Ande, Edwin W. Brown, Clarence L. Brumback, V. Marklin Johnson, Walter R. Newbern, Ralph M. Overstreet Jr., W. Lawson Shackelford, Edward W. Wood
PASCO-HERNANDO-CITRUS—S. Carnes Harvard
PINELLAS—Clyde O. Anderson, Harry R. Cushman, N. Worth Gable, Norval M. Marr Sr., George H. Schoetker, Walter H. Winchester, Rowland E. Wood (*Absent—M. Eldridge Black, Willliam D. Futch, Percy H. Guinand, Joseph W. Pilkington, James E. Thompson*)
POLK—Jere W. Annis, James R. Boulware Jr., Marion W. Hester, Charles Larsen Jr. (*Absent—Samuel J. Clark*)
PUTNAM—(*Absent—Lawrence G. Hebel*)
ST. JOHNS—Herbert E. White
ST. LUCIE-OKEECHOBEE-MARTIN-Richard F. Sinnott
SARASOTA—John M. Butcher, Karl R. Rolls, Melvin M. Simmons
SEMINOLE—Daniel H. Mathers
SUWANNEE—(*Absent—Edward G. Haskell Jr.*)
TAYLOR—(*Absent—John H. Parker Jr.*)
VOLUSIA—C. Robert DeArmas, Alphonsus M. McCarthy (*Absent—William R. Hutchinson, Arthur Schwartz*)
WALTON - OKALOOSA - SANTA ROSA—(*Absent—Frederic E. Caldwell*)
WASHINGTON-HOLMES—(*Absent—Walter H. Shehee*)
STATE OFFICERS—Samuel M. Day, James T. Cook Jr., Francis H. Langley, Cecil M. Peek, Shaler Richardson, William C. Roberts (*Absent—Meredith Mallory, Kenneth A. Morris*)

Dr. Leo Wachtel gave the invocation.

Dr. Jere W. Annis moved that the delegates be seated.

Seconded by Dr. Milton.

Motion carried.

President Roberts introduced several guests: Dr. William J. Kennard, Assistant Director A.M.A. Washington Office; Major General Paul I. Robinson, Executive Director, Office for Dependents' Medical Care; Mr. John D. Arndt, Medicare Administrator, Medical Association of Georgia; Dr. Russell B. Carson, President, Mr. H. A. Schroder, Executive Director, and Mr. N. G. Johnson, Medicare Coordinator, of Blue Shield

of Florida; Mr. Harry T. Gray, the Association's Attorney; Mr. Marshall Brainard, Executive Secretary, Duval County Medical Society, and Mrs. Berneice T. Mathis, Executive Secretary, Orange County Medical Society.

Dr. Roberts announced that this meeting had been called for the purpose of deciding the future of Medicare in Florida and only that subject could be discussed.

Dr. John D. Milton, Chairman, Medicare Mediation Committee, gave an excellent illustrated address on the history, scope and present status of the Medicare Program in Florida.

Medicare in Florida

JOHN D. MILTON, M.D.

Chairman, Florida Medical Association Medicare Mediation Committee, Miami.

In a period of some twenty minutes, I shall endeavor to cover Medicare prior to July 1, 1957, and to present some of the problems that have been causing difficulties since that date.

The Association's Mediation Committee and Blue Shield of Florida have worked with Medicare for months, but we still find it necessary to move slowly and to feel our way along. I am certain that the physicians who are providing services to eligible dependents are finding this true also.

Your Mediation Committee is strictly professional and has nothing to do with the administration of Medicare. There are so many ramifications that it is unusually hard to interpret properly any given claim.

This (Slide No. 1) is an attempt to summarize concisely for you the types of care that are authorized under the program. You will note that this is primarily an in-hospitalization plan and only during hospitalization will Medicare pay for (1) the treatment of acute medical conditions including exacerbations or acute complications of chronic diseases, (2) the treatment of surgical conditions, and (3) the treatment of contagious diseases.

Medicare does provide complete obstetric and maternity care. This is the one instance where no restriction is placed regarding hospitalization. The care may be provided in the hospital, home or office.

Medicare also provides up to 365 days hospitalization in semiprivate accommodations for each admission.

It also provides care in a hospital for bodily injury (Slide No. 2) and treatment in a hospital of acute emergencies of any nature.

Payment for diagnostic tests and procedures is authorized only during hospitalization except that (1) payment is authorized in an amount not to exceed $75 for necessary diagnostic tests and procedures performed or authorized by the attending physician prior to hospitalization for *the same bodily injury or surgical procedure for which the patient is hospitalized,* and (2) payment is authorized in an amount not to exceed $50 for necessary diagnostic tests and procedures performed for proper after-care of the *same bodily injury or surgical procedure.*

As previously stated, Medicare is essentially an inpatient program, providing for outpatient care in the following areas: (Slide No. 3) (1) obstetric and maternity services, which have the greatest utilization of any of the services provided under Medicare and provide the one exception to limitation on where the services shall be performed; (2) bodily injuries, limited to the treatment of fractures, dislocations, lacerations and other wounds; (3) diagnostic tests and procedures prior to and/or following hospitalization for the *same bodily injury or surgical procedure for which the patient is hospitalized,* and (4) radiotherapy prescribed during a period of hospitalization and continued or carried out on an outpatient status, as directed by the attending physician.

EMERGENCY CARE. — As you have noted in the information just presented, (Slide No. 4) emergency care, to be payable by the government under the Dependents' Medical Care Program, must be either: (1) outpatient care as stated previously, which is normally provided for under the program: or (2) care furnished to the patient who is *admitted to a hospital as an inpatient* irrespective of whether the hospital meets the definition of a hospital as defined in the Joint Directive.

Thus, emergency care performed in a doctor's office or clinic, which is not related to an obstetric or injury case, is not compensable under the program.

Your Association participates jointly in a three way contract (Slide No. 5) with the Contracting Officer of the Office for Dependents' Medical Care, representing the government, and Blue Shield of Florida, the fiscal agent, the Association operating in a capacity primarily of professional mediation.

The original contract is still in effect (Slide No. 6). It was not changed by the action of the

House of Delegates in May 1957, as will be explained in greater detail later. The changes produced by the decisions of the House were those of implementation and in no way altered the existing contract.

The contract spells out the responsibility of the three participants. (1) It is the responsibility of the government, that is, the Office for Dependents' Medical Care, to be the final authority in the payment of claims which deal with special reports and special procedures. (2) Blue Shield, the fiscal agent, deals merely with the processing of claims. When a claim is received by Blue Shield, it must check the service information on the dependent and the sponsor, and it must determine whether the procedure is allowable under Public Law 569, whether it comes within the maximum allowances, and whether it is properly certified. If all these are in order, then the payment of the claim is made immediately to the physician by Blue Shield.

It is the duty and responsibility of the Florida Medical Association to encourage physicians to provide services to eligible dependents and to maintain appropriate committees to review and consider cases involving complaints, differences of professional opinion and misunderstandings. (Slide No. 7 - a continuation of the original contract).

Fees. — Under the original contract, fees were paid according to the Schedule of Allowances which the Association had negotiated with the Office for Dependents' Medical Care. In case the particular procedure on the claim was not listed in the Schedule, or in involved cases, a special report was required to be submitted with the claim. It was the Association's duty to review these to determine the tentative fee, which then had to be approved by the Contracting Officer. The tentative determination of the committee became final unless rejected by the Contracting Officer within 20 days.

Also, under the original contract, any item in the Schedule which was deemed inequitable could be increased or decreased at any time after adequate review. The period of that original contract extended from December 10, 1956 to June 30, 1957. December 10 is the actual date of the beginning of the contract, but payment for authorized care under the program was permitted from the date the law went into effect, December 7, 1956. (Slides No. 8 and 9 - The Beginning of a New Era).

The action of the House of Delegates, May 8, 1957.

Resolution

WHEREAS, the Florida Medical Association desires that the Medicare program be carried out on the American principle of freedom of choice of physician and the freedom of the physician to set his own fees, based, not on a standardized formula or fixed fee schedule, but on the usual fee charged for such services, and

WHEREAS, we have a firm conviction that better medical care for the dependents will be provided, at lower cost to the taxpayer; the present satisfactory physician-patient relationship continued and incentive for advancement in medical training and practices maintained, if military dependents are cared for on the same basis as other citizens,

BE IT THEREFORE RESOLVED:

1. That the fixed fee schedule contract now in effect NOT be extended beyond the termination date of June 30, 1957.
2. That the Florida Medical Association Board of Governors devise a mechanism to provide dependents with medical care under the provisions authorized by law until a new contract has been consummated.
3. That the Florida Medical Association negotiate a new contract carrying out the principles of this resolution.
4. That the Florida Medical Association and each County Medical Society establish a committee to evaluate and recommend the disposition of problems related to the Medicare program.
5. That a copy of this resolution be forwarded to the Secretary and General Manager of the American Medical Association.

(Slide No. 10 — Action of the Board of Governors, May 26, 1957).

The action of the House of Delegates directed the Board of Governors to carry out the mandate of the House and to devise a mechanism to provide dependents with medical care under the provisions authorized by law until a new contract was consummated.

In accordance with these instructions, the Board of Governors on May 26, 1957, approved the following actions with reference to Medicare:

1. The Florida Medical Association and its fiscal administrator jointly announce that no fixed fee schedule on the Medicare program exists after July 1, 1957.
2. Physicians will henceforth submit to Blue Shield of Florida their usual fees with due reference to the income level of service men and the special groups receiving those services.
3. The Florida Medical Association will process fees submitted and decide whether they are equitable under the circumstances in each case.
4. This contract will be extended until January 1958 at which time a new contract will be negotiated and annually thereafter.

I should like to ask that you take specific note that these actions of the Board of Governors

were transmitted to the Office for Dependents' Medical Care in a letter dated June 17, and at General Robinson's insistence, the following sentence was added: (Slide No. 11) "This resolution will in no wise abrogate our present contract but will merely change the implementation of same, and further, it is to be understood that this change in process or implementation *will not increase the cost to the Government.*"

You will recall that earlier in my remarks, I stated that there was no change in the contract, merely in the implementation of it.

General Robinson replied on June 27, 1957: (Slide No. 12).

> "We agree with the point you made that your letter in no way abrogates the Contract as extended through 31 January 1958. We feel that the Contract speaks for itself. To incorporate the contents of this letter into the Contract could very well result in a misunderstanding as to the terms of the Contract. The Contracting Officer in executing this extension of the Contract is doing so with the understanding that the contents of the above referenced letter are not incorporated into the Contract, and in no wise abrogates the Contract.
>
> "Since the fees, in the Schedule of Allowances for Physicians' Fees, set forth in the Contract are 'maximum fees', we feel that your association has acted wisely in discontinuing publishing fees to physicians, requesting physicians to bill their normal charges, and with your association and its counterparts at the local level acting as a leveling influence."

Slides 13 and 14 deal with that portion of DA Form 1863, the Medicare claim reporting form, which has to do with certification. Improper certification or lack of certification has caused considerable difficulty in the processing of some claims and probably has created as much misunderstanding as any one item.

Slide 14 is a blown-up version of that portion of DA Form 1863 which provides for certification by the attending physician. It is necessary that you check either "A" or "B". You will note that if you check "A", you agree to accept the allowances listed in the Dependents' Medical Care Program Schedule of Allowances or the amount which you have shown in Item 24, whichever is less. As you will see on subsequent slides, if you check in this block and your claim does not exceed the current Schedule of Allowances, the processing of the claim is simple and payment will reach you in a minimum of time. If, however, you check "B" and the amount is higher than the Schedule of Allowances for that procedure, it must be sent to ODMC for approval and must be accompanied by a special report justifying the additional charges.

The routing of a claim form *prior* to July 1, 1957 is shown in Slide No. 15. You will note the relatively simple procedure if you checked "A" and the amount did not exceed that in the Schedule of Allowances; your claim went to Blue Shield, and if it was filled out properly and was an allowable service under the Medicare program, Blue Shield paid the claim immediately, and you had your money in a very short time. If, however, you checked "B", or if there was some question as to whether the procedure was authorized, the claim went to the FMA Mediation Committee, back to Blue Shield, then to the Office for Dependents' Medical Care, and back to Blue Shield. If it was recommended for payment by FMA and ODMC concurred, then Blue Shield was authorized to make payment as soon as ODMC indicated its approval.

The more complicated procedure necessary *after* July 1, 1957 is set forth in Slide No. 16. Again, if you have checked "A" in the certification section of the claim form, the process is still as simple as it was previously. If the claim is allowable and you have filled in the form properly, Blue Shield can pay the claim immediately. If, however, you have checked under "B", the claim will go to your County Medical Society Mediation Committee, back to Blue Shield, then to the FMA Mediation Committee, back to Blue Shield, to the Office for Dependents' Medical Care, and back to Blue Shield. If approved by ODMC, payment can then be made by Blue Shield, but you can readily see that this procedure will take considerable time, particularly since county and state mediation committees probably will not meet oftener than once each month.

Once a claim form goes to ODMC with the county and state Medicare committee recommendations, it will not rest there indefinitely until ODMC gets ready to act. If the claim has not been rejected by ODMC within 20 days, Blue Shield may go ahead and pay without waiting for further instructions.

Another requirement which is greatly misunderstood and which has caused considerable con-

fusion is special reports. (Slide No. 17) This slide is intended to show the general conditions under which special reports should be made:

1. Complications of pregnancy for which additional fees are charged.
2. Surgical operations not properly listed in the Schedule of Allowances or any unusual and trying circumstances.
3. Severe complications of medical illnesses, which require more than usual hospital visits.
4. Every case of hospitalization for nervous or mental diseases. The report *shall* state that the life, health or well-being of the patient would have been endangered if not treated.
5. Every case in which fees are above previous schedule for any reason.
6. Cases in which two or more physicians are required at the same time. (Supplemental skills)
7. Those procedures previously annotated as "By Report."

The general rule of thumb is that when any complications arise, or whenever additional charges are made, if the fees exceed the Schedule of Allowances, a special report will have to accompany the claim form.

It occurred to me that a few statistics might be helpful. Slide No. 18 shows cases referred to the state committee up to October 31, 1957: (Slide No. 18)

Complicated Surgery and Related Procedures	147
Maternity and Complications	101
Consultants' Services, Surgical Assistants, Consultations, etc.	49
Charges in Excess of the Schedule	35
Psychiatric (Acute Emotional)	35
Elective and Chronic Care	31
Complicated Medical Problems	26
Outpatient Diagnostic Procedures, with and without Therapy	21
Supplementary Skills	14
Committee Function, Pediatrics, Nonscheduled Procedures, Transient Surgery, Medicare and Insurance, Allergy Tests and Dental Problems	37
Total	496

You will note that heading the list is complicated surgery and related procedures, followed by maternity and its complications. Keep in mind that these figures pertain only to those cases referred to the committee and not to total claims processed.

In Slide No. 19 an attempt is made to compare utilization of Medicare in Florida with that of the entire nation. It shows that Florida's percentage has increased and that the number of dollars coming into the state is not insignificant.

Medicare Claims
December 7, 1956 - June 30, 1957

	Florida	Nation	Florida % of Total
Number	6,031	127,902	4.7
Amount	$425,397.38	$8,805,128.00	4.8
July 1, 1957 - August 31, 1957			
Number	4,099	45,748	9.0
Amount	$319,053.45	$3,288,805.00	9.7
September 1, 1957 - November 1, 1957			
Number	4,279	Not available	—
Amount	$332,894.69	Not available	—

Let us think again for a moment of the resolution passed by the House of Delegates last May. You will recall that we made a definite promise to the government that if physicians were allowed to charge their regular fee, or the fees usual to their community, not only would the expense to the government not be more, but actually it would be "at a lower cost to the taxpayer."

Number of Cases below Schedule from July 1, 1957 to November 1, 1957 (Slide No. 20)

Florida Figures Only:

324 Cases—Amount below Schedule of Allowances—$3,397.75

Paid in same period:

8,378 Cases — Total for these cases — $651,948.14

Per cent of cases paid below Schedule to total cases paid—3.86 per cent

Per cent of money below Schedule to total amount paid—slightly more than 0.5 per cent

Slide No. 20 shows that to date, from the aspect of saving the taxpayer money, we do not have much of a talking point. The total amount of money paid to physicians below that which would have been paid had we adhered to the Schedule of Allowances is just slightly over 0.5 per cent. It could be added that it probably would have been higher had not the ODMC declined to approve charges in excess of the Schedule of Allowances which were not justified by special report.

We thought that you might be interested in a breakdown by medical districts of the amounts

which are below the Schedule. The selection of the counties in each district was made on the basis of those having the greatest utilization for their area. Compared to the total amount of money paid for Medicare in these counties, the figures are indeed insignificant.

Amounts Below Schedule By Medical Districts
(Slide No. 21)

District	*Principal Counties*		*Total for District*
"A"	Escambia—	$487.50	
	Bay—	243.00	$ 898.25
"B"	Duval—	694.50	
	Orange—	581.00	1,574.00
"C"	Hillsborough—	235.00	
	Polk—	128.00	565.00
"D"	Dade—	156.50	
	Martin—	93.50	360.50
Below Schedule—Total All Districts			$3,397.75

We are here today to determine what course we are going to follow in Florida from here on. As we attempt to arrive at sound and logical conclusions, it may be helpful to contemplate what will happen if our present plan is not successful and we do not renew our contract. (Slide No.22) If we refuse to renew our contract, the Office for Dependents' Medical Care may

1. Ask the Third Army to care for dependents in Florida. This might mean care in army facilities by army doctors, or
2. Invoke a fee schedule and place administration either in the hands of the Third Army or a private insurance company. If this should happen
 a. Medical service would be provided by physicians who would accept whatever fees the government wishes to pay.
 b. Neither the individual physician nor the Association would have a voice in setting those fees.
 c. Inclusion of other groups by Congress, with fees set at any level the government wishes, would be facilitated.
 d. Socialized medicine would be extended.

Unquestionably, the eyes of the medical profession of the nation are on Florida. (Slide No. 23) That is evidenced by the number of inquiries that have come to the executive office from other state medical associations and the fact that one neighboring association has elected to send a representative to this meeting.

If Florida physicians are honest and fair in the handling of each and every Medicare claim, it will

1. Prove that an inflexible Schedule of Allowances is not necessary.
2. Preserve the rights of individual physicians and the physician-patient relationship.
3. By precept, enable other states to negotiate similar contracts with ODMC.
4. Retard the current trend toward socialization of medicine.

And now the decisions (Slide No. 24) which this House of Delegates must make include:

1. Shall the Association continue to be a party to a contract with the Office for Dependents' Medical Care?
2. If so, shall it be on a fixed fee (Schedule of Allowances) or on a no fixed fee basis?
3. If a fixed fee is preferred, what changes from the previous Schedule of Allowances should be required?
4. If a no fixed fee is to be in effect, shall the Association accept the government's policy of adhering to a maximum fee schedule?
5. Selection of representatives for renegotiation of contract in January 1958.

Gentlemen, that is Medicare from the viewpoint of those who have been working closely with it since its inception. Where we go from here is in your hands and depends upon the decisions which you now must make.

Dr. Milton: "It is a pleasure for me to introduce your next speaker. I am sorry that I have not had the pleasure of knowing this gentleman much longer than I have. I can assure you that all the dealings I have had with him, and the others who have come in contact with him, convince me that he is a real gentleman, and that, being a doctor, he is on the side of medicine much more than you would judge by his uniform. He really wants medicine to call the shots. I am sorry that I do not have all of his background, but you can see from his ribbons and his rank that he has been through everything and has shown his ability. I present to you General Paul I. Robinson."

The Dependents' Medical Care Program

MAJOR GENERAL PAUL I. ROBINSON, (M.C.)
B.S., M.D., F.A.C.P.

Executive Director, Dependents' Medical Care Program
Office of The Surgeon General, U.S. Army, Washington, D.C.

Dr. Roberts, Dr. Milton, Physicians of the Florida House of Delegates: I want to assure you

that I appreciate very much the invitation to meet with you today.

I have a series of Vugraphs which I believe will make my presentation shorter and more readily understandable. (Chart No. 1)

We should all keep in mind the purpose of the law. This is quoted directly from P. L. 569. The purpose of this act is to create and maintain high morale throughout the uniformed services by providing an improved and uniform program of medical care for members of the uniformed services and their dependents.

(Chart No. 2)

This slide is one that the committee who prepared the Joint Directive used. This is an exhaustive study to determine what the income of service people actually is. You will notice that they included not only the base pay but all the allowances now given to service people. You will notice also that nine out of 10 service personnel have incomes less than $5,000. Actually, the figures I have used in many presentations over the country is that 82 per cent have incomes of $4,300 or less. You can readily see that those who have incomes of over $5,000 are really a very small per cent.

The next slide may be difficult to see for those in the back of the room. I tried to outline the plan of the Program hereon. The Medicare Plan we must consider as an absolutely new plan. It does not conform to any insurance scheme; it does not conform to any Blue Shield plan. This plan is for wives and children of active duty service men, and dependents of active duty service women (we have a few nurses who have dependent husbands) of the Army, Navy, Marines, Air Force, Coast Guard, commissioned members of the Public Health Service and Coast and Geodetic Survey. It covers all authorized inpatient care and all outpatient care incident to complete maternity care and bodily injury, and excludes care for chronic illnesses, nervous and mental diseases and elective surgery.

Authorized medical care may be received in civilian hospitals if the dependent wishes and if the dependent pays a stipulated amount. Service can be rendered by civilian physicians if they desire to accept the patient under the program, under standards of civilian medical authorities, at amounts not in excess of rates which are determined by negotiation between the state medical associations and the Office for Dependents' Medical Care. Bills are paid by Blue Shield, by state medical societies themselves in some states, by commercial insurance companies in some states and at a nonprofit administrative cost. Bills are paid from funds appropriated by the Congress and are provided to create and maintain high morale, you must remember. You will recognize this slide has a third column, and so you will know I am not keeping anything from you; it is the hospital part of the Program in which you are not too interested.

(Chart No. 3)

Dr. Milton went over the care authorized much better than I, but I thought I would show these slides anyhow because there is a little difference in the care rendered in service facilities and in civilian facilities. There is a little more leeway in service facilities. I think that is important for you as civilian doctors to remember, particularly in those cases which you question. The important thing I think is that throughout our entire nation, Alaska, Hawaii, and Puerto Rico, there is an absolute free choice by the dependents, whether or not they will go to a service facility or a civilian facility. Right here, I might say that there is a provision in the law for this free choice to be restricted by the secretaries of any of the services, provided the Secretary of Defense will approve. There has been no application for restriction made from any area at this time. Applications may be made, in the future, particularly in certain fields in order to protect the residency and internship training programs of some of our large hospitals, but at the present time there have been none, and we hope there never will be.

This slide shows care not authorized. I sat with Dr. Milton's committee until twelve-thirty last evening, and I assure you that his committee is working very hard on just these items about which most of the questions arise. Whether or not medical care rendered for a chronic disease really is allowable under the Program creates many questions. There is no line that we can draw yet. We have been unable to write a directive delineating what procedures and treatments can and cannot be accomplished. We will do so as soon as possible. For nervous and mental diseases we did so in our ODMC letter No. 8, which outlines acute emotional disorder care.

In the area of elective medical and surgical care, we have a tremendous amount of difficulty, as Dr. Milton can tell you. Whether or not a rhinoplasty is approvable; whether or not an elephant ear operation is approvable; or scar cor-

rection on a previously accomplished hairlip, those are most difficult decisions, and there just is no generally applicable answer at present. We have to judge each case on information furnished by physicians. I am sure it is a nuisance to you to have questions come back to you for detailed explanations so that we can try to adjudicate the claims reasonably and correctly. Here again, in this area, it might be well for you, as civilian physicians, to suggest to the patients that they might present themselves to a Service facility for this questionable care or to seek decision before treatment is accomplished.

(Chart No. 4)

The patient has to pay a considerable amount. I talked to a young fellow the other day; his wife had had hospitalization for a minor gynecologic procedure, and his two children had had tonsillectomies. He had paid $75. I talked to some of my insurance friends, and they said that for $75 he could have obtained considerable insurance; so, it is not a give-away program, and we should remember this fact. Dependents must pay the first $25 or $1.75 per day, which ever is greater. If they have a private room, they must pay the difference between the private room and semiprivate accommodations, unless the physician specifically says that the patient must have a private room in order to render proper care. The patient has to pay all private nurse charges unless the physician prescribes, and even then she must pay the first $100 plus 25 per cent of the additional. The patient must pay all outpatient care, all care that is ordinarily rendered on an outpatient basis, except for bodily injury or maternity delivery (not in hospital) when she must pay the first $15 of the physician's charge. All x-ray, laboratory, preoperative tests over $75 and posthospital over 50 per cent must be paid by the patient. For deep x-ray, posthospital, there is no charge for a condition treated or diagnosed while in the hospital, but there must be a hospital connection.

The next chart is the new identification card. Beginning the first of January, no identification is acceptable except this card. The services have had nearly six months to distribute this card, and if anyone presents himself to you after the first of January with any identification other than this, he should be questioned most carefully, except, of course, in an emergency to save life and limb, and then you can fall back on the standard principles of medical practice.

(Chart No. 5)

I thought you all might like to see the present setup of fiscal administrators. In all the states in dark blue, Blue Shield is handling the plan. In all the states in red, the medical associations themselves are handling their own plan. In Oregon and Washington, the professional association has designated Blue Shield to handle everything; they make all the decisions that the Medicare Mediation Committee here makes. The decisions are all made in the Health Plan offices, but I am sure with medical advice in many instances. Alabama and Louisiana suggested private insurance companies to pay the bills, and we made contracts with them.

Rhode Island and Ohio, as you all know, would enter into no contractual arrangement. Ohio representatives sat with us and worked out a schedule of allowances which is in effect. We contracted with Mutual of Omaha to pay the physicians in Rhode Island and Ohio. We have an acceptable program in both states. Between 15 and 25 per cent of all physicians in those states are participating in the Program. The questions, however, have to come to our office; we, in turn, have to deal with the individual physician. The medical associations do not enter into the operation of the Program. As far as our relationships with the individual physician are concerned, they are excellent. In Hawaii, Blue Shield pays the physicians; in Alaska, the Blue Cross of Washington; in Puerto Rico, the medical association itself. Remember, all of the state medical associations had the option of deciding whether or not to do their own fiscal work, and we approved their selection of fiscal administrators if they had proper offices and our auditors thought that they could do the job.

(Chart No. 6)

In the beginning of the Program, everyone wanted to be very sure that we did not have a national Schedule of Allowances. I just slipped in two or three slides here on the schedule to let you see the differences. Hospital visits range from $3.90 to $10; fees for nephrectomy from $175 to $420; appendectomies from $125 to $210; maternity care (complete, including antepartum and postpartum care) from $120 to $180. Here are 18 more items that are plotted a little different way—the range there is shown—bronchoscopy for removal of foreign body, $70 to $125, the average is $107, and 15 states have $100; tonsillectomy, the range is $42.50 to $75, the average is $64, and 15 states have $65; herniorrhaphy from $100

to $180, the average is $138, and 17 states have $150; classic cesarean section from $110 to $300, the average is $203, and 11 states have $200. There is a wide variation even in diagnostic x-rays; complete spine, $25 to $60, average is $42, and 27 states have $45. We plotted some items by states: for tonsillectomy, all of the states in blue have $65; all of the states in red have $75; Michigan happens to be low with $42.50; and all the states in white are somewhere between $42.50 and $75, but not $65.

These are complete maternity care, all blues have $150; the two reds have $180; Oklahoma and Puerto Rico, $120; the white states are all in between $120 and $180, but not $150.

This is hospital visits, all blue have $5; Oregon has $3.90; Alaska has $7.50; all the white states have some figure in between.

(Chart No. 7)

Our business is 80 per cent female, as you can see, the 20 per cent male being under 13 years of age; this is to be expected in the Program. Of course, the big bulk of our dependents are between 20 and 29 years of age. This is a statistical study of 5,000 cases taken at random.

(Chart No. 8)

Here is our business from the standpoint of diagnosis. The medical and pediatric care is practically all accounted for in the hospital visits, as you know, about 23 per cent; maternity in the neighborhood of 37 per cent, including the complications and circumcisions; tonsillectomies account for about 17 per cent; female genital system, 8 per cent; abdominal operations, less than 5 per cent; skin, less than 3 per cent; and musculoskeletal, less than 1 per cent. It seems that we have had a very small number of accidents. The other procedures amount to 5 per cent and these include the direct billing for laboratory and x-ray service.

(Chart No. 9)

Every month we take the bills that come in that month and roll them back into the month that the service was rendered, and I think this chart very clearly depicts the volume of the Program. In October, for example, we received 150 bills for service rendered in December 1956. We think it is going to be 18 months before we know positively what the Program is going to cost, but I think there is no question at all that the Program is going to run close to 6 million dollars a month. You can see that we are up to 5.5 million in April, May and June. These bars are split between hospital and physicians. When this chart was prepared, $41,000,000 actually had been paid out by our office to reimburse fiscal administrators; $21,000,000 to physicians; and $20,000,000 to hospitals. We are running about 4,000 cases each day in civilian hospitals under this Program; the average patient stay is about 5.3 for the over-all program.

(Chart No. 10)

We wanted to look into diagnoses and costs and selected eight states; Florida is one of these states. We actually matched physician and hospital claims for this study, which is a terrific statistical job; the people told me it took 13 separate sortings to compile this study and, as a consequence, they do not want to do very many of them. At any rate, we felt the need of this study, and so we went into it. This study included 8,326 cases and $1,743,349, and so it is possibly a big enough study to be reasonably representative. I think it is interesting to see that, in maternity deliveries, the number of cases corresponds rather closely to the number of dollars. The number of cases of tonsillectomies is somewhat less a proportion than the dollars involved, as you can see. The amount which the Government paid was $209.39 per case, or a total of $49.59 per patient day. We must remember that the antepartum care is in this study. The eight states used in this study were California, Colorado, Florida, Kentucky, Texas, New York, Washington, and Wisconsin.

(Chart No. 11)

We took all the cases that appeared in this study more than 45 times and charted them by cost. Now, remember, this is hospital plus physicians cost. Uterovaginal prolapse was No. 1 at $508; appendicitis, $335; hernia, $295; hemorrhoid, $290; other GYN conditions, $233; maternity deliveries, $224; complications of pregnancy, $171; respiratory infections, $164; miscarriages and abortions, $155; gastroenteritis, $132; tonsillectomies, $113; all others not listed as many as 45 times averaged $273 per case.

(Chart No. 12)

In this study we took the over-all program as of the end of September, and we estimated how much antepartum care had been included in the per diem cost of the eight state study to try to arrive at a more realistic cost per day. We estimate that the cost per hospital day, eliminating the outpatient care, is approximately $38.33. Now we realize that this study can be challenged,

but, on the other hand, it is the best estimate we can make at the present time.

(Chart No. 13)

This is a selective study on acute emotional disorders which was made in May. We were very anxious to find out what was happening in these cases. You can see that the majority stayed in the hospital less than three days, and only a very small number stayed over 21 days. This study was made before ODMC Letter No. 8 really got into effect. The average stay was 7.4 days and the average cost, $32 a day for this particular group.

(Chart No. 14)

I do not know whether there are any anesthesiologists in the audience or not, but I thought you might be interested in seeing this chart. There are so many ways in our schedules of calculating anesthesiology fees that I prepared this slide showing 10 of them and took it to the American Association of Anesthesiologists meeting in Los Angeles a few weeks ago. You will notice that state "A" calculates its fee by $20 for the first half hour, $7.50 for the next two quarter hours, and $5.00 for each quarter hour thereafter; state "B" has $20 for the first half hour, $5, $5, and $5 for the quarters; it runs on down to state "G" which has a specific amount for each item; and another state has, if the surgery fee is under $75, a flat $15, and if over $75, 20 per cent of the fee. Another one has 20 per cent of the surgical fee, plus $5. The American Association of Anesthesiologists passed a resolution at this meeting to the effect that they would prefer that anesthesiologists have a stated fee for each procedure without regard to time. In our new Schedule of Allowances, which we expect to negotiate with you, we will allow you to continue any of these methods, but if you want to go to that fee for item basis as the American Association of Anesthesiologists would like to be done, we will negotiate along those lines.

(Chart No. 15)

We sent out questionnaires on this Program to see what the recipients think about it. Of course, we were interested in knowing how the information was getting around. This is the result of about 200 returns.

Where did you first find out about the Program? Sixty-three per cent said from the husband; 13 per cent, from Service publications; 11 per cent, from newspapers, and 11 per cent from other sources.

Did your physician have the necessary Program information? Eighty-four per cent said yes; 16 per cent, no.

Necessary forms? Eighty-eight per cent had the forms; 12 per cent, no.

Did the hospital to which you were admitted have the necessary Program information? Ninety-four per cent said yes; 6 per cent, no.

Necessary forms? 96 per cent said yes.

Did you have a choice between military and civilian hospitals? Forty-eight per cent said yes; 62 per cent, no.

Were you generally satisfied with the care you received? One hundred per cent said yes.

(Chart No. 16)

We asked for comments, and 31 per cent were extremely favorable toward the Program; 7 per cent were unfavorable, said that the convalescent period was too short, they should not have to pay the hospital $25, the forms were too complicated, and they received less respect than other civilian patients. Others would like to have more coverage under the Program; dental care is always very prominently mentioned; outpatient pediatric care, et cetera.

(Chart No. 17)

This is a later study in which we are emphasizing more why the patient went to a civilian facility. Fifty per cent said they resided too far away from a military facility; 28 per cent said that the type of care rendered at the military facility was not the type of care they had to have; 13 per cent said the military facility was inadequate or overcrowded; 12 per cent said they just preferred the care of civilian facilities; 8 per cent said they liked a particular doctor; and 3 percent said they were emergency cases and could not get to a military facility.

(Chart No. 18)

In the comments on this second questionnaire, 27 per cent were extremely pleased; there was still about the same group who want extension of the Program to dental care, outpatient care, et cetera, but for the first time, 2 per cent said, "We have tried your civilian program; we are going back to military."

(Chart No. 19)

These are the claims from Florida which reached our office between 11 September and 20 September. I just had them plotted here to see if they were all bunched in one area; they are not. It appears that every hamlet in Florida is represented in that 11 days. I think that is significant also for your own consideration. I notice in Lake

City there are two cases; in Gainesville there are six cases; in Starke there are two cases; in Quincy, three cases. Of course, the bulk of the cases are in Greater Miami, Jacksonville, Pensacola, and Palm Beach, but I think that is to be expected. There are not very many in Key West, only 7. I thought you might be interested in seeing that you do have a tremendous distribution of cases in your state.

Dr. Milton has given you a number of statistics which are very much more up-to-date than any statistics which I have so far as Florida is concerned. I have some other facts, however, which I think perhaps you will like to know.

According to the 1956 A.M.A. registry, you had 4,530 physicians registered in Florida, and as of 31 October 1957, 1,617, or 35.7 per cent, have participated in the Medicare Program. Of the 2,509 special reports we have received from all the states, 111, or 4 per cent, have been from Florida. Florida is the third highest in the number of physicians' claims paid; California is first; Texas, second; Florida, third; and Virginia, fourth. This is for your information.

For maternity cases, your average stay in the hospital has been 4.7 days; surgical cases, 4.3 days; and medical cases, 7 days. Percentagewise, 44 per cent have been for maternity care; 38 per cent, surgical; and 18 per cent, medical. You are running less medical than the country as a whole.

Your average physician's claim has been $74.37; the average claim for physicians all over the "nation, Florida included, is $71.00.

Of the 1,655 physicians who have participated in Florida, 1,161 have collected less than $500; 233, between $500 and $999; 213, between $1,000 and $10,000; 17 between $10,000 and $20,000; 6 between $20,000 and $30,000; 4 between $30,000 and $40,000; and one, $54,000. *(Erroneous. See Note)*

Florida is scheduled to be our first state in the nation to negotiate the new schedule, and I think your dates are January 6 and 7. We have worked diligently during the past year to take the experience we have had all over the nation, and the suggestions that have been made by wonderful committees like Dr. Milton's, and incorporate them into a schedule which we can negotiate. We hope, at least 90 per cent of the questions which have arisen during the past year will be thereby resolved. I was able to get two copies of this new publication before I left Thursday. You will have your copies within the next few days. There are a few things which I would like to mention.

The internists, in particular, have raised a great many objections to the fact that the schedule does not include a fee for complete physical examination. This new schedule will have such an item; I would like to read it to you.

> "*Complete history and physical examination for a case of a medical nature during hospitalization of adults.* This may be used in lieu of the initial hospital visit, Code 0012, for medical patients presenting difficult diagnostic or therapeutic problems. Patients will often be seriously ill, necessitating a prompt, comprehensive study requiring a complete and detailed, written medical record. A copy of this record may be requested by reviewing authorities."

In other words, if Dr. Milton's committee has any question, he can ask you as the billing physician to please furnish him a copy of that record. Only one such procedure is authorized per admission.

This has been worked out very carefully with internists, but we felt we could not include a statement they would like to have to the effect that this item should apply only to the practice of internal medicine.

There is also a similar item for examinations for children.

We included a section on psychiatry so that there would be some kind of a fee scale to pay the psychiatrists who take care of acute emotional disorders. It includes initial examination, shock therapy, insulin therapy, somatic therapy of various kinds, and psychotherapy. We have not included psychologist's examination. We went to the psychiatrists and discussed this very carefully, and it is their opinion that any case which requires a psychologic examination is beyond an acute emotional disorder state and is not included in the Program.

We have rearranged the Surgery Schedule. There will be a fee negotiated for what we have now, except we have stipulated the number of days of postoperative care, which are included in the maximum fee. We have also stipulated the number of posthospitalization visits which are the government's responsibility and they, of course,

Note: General Robinson apologizes for making the above statement which was later found to be erroneous because of faulty machine tabulation. The statement should read:
"Of the 1,617 physicians who have participated in Florida, 1,132 have collected less than $500; 245 between $500 and $1,000; 214 between $1,000 and $5,000; 21 between $5,000 and $10,000; 3 between $10,000 and $15,000; and 2 more than $15,000."

are also in the surgeon's fee. In some areas in the country, we have a number of surgeons who just come in and perform the operation and the general practitioner assumes the postoperative care. So, we have a fee for surgery only.

There are other changes. As far as the maternity schedule is concerned, we have two methods. Some of the states like the trimester method of calculating; others have indicated, and Florida is one, that they would like a visit basis. We have provided both methods so that the states can have one or the other. We, of course, cannot negotiate both.

I would like to say, after sitting with Dr. Milton and his committee last night, that I think Florida physicians are very fortunate in having such careful study and care given to their problems. The majority of the problems arise in the elective surgery category. We have gone through this schedule and have marked every item where questions are arising with an "E", and we have advised, in this schedule, physicians, who have cases needing any of these procedures, to study them very carefully and if there is any doubt in their mind, to present them for decision before they perform the surgery. Actually, none of these are ever of an emergency nature, I believe.

I am sure that I could talk on and on; it is a great pleasure. I believe you have a good program in Florida; I hope you continue it. You will have a maximum schedule. Whether you publish it or not does not matter. I would personally prefer that you do not publish it; I would like you to continue the way you have during the past, because I think it is much easier for the county committees and the central committee to adjudicate whether a claim is reasonable if they do not have a schedule in everyone's hands. The schedule has been negotiated and will be negotiated again as a maximum schedule. I think you all realize if everybody charges maximum, sometime somebody is going to question it.

Dr. Roberts: "General Robinson, I want you to know that I, personally, and the House of Delegates appreciate your most complete contribution from the government standpoint and presented in such a friendly manner."

Dr. Roberts introduced Dr. Kennard.

Dr. Kennard: "Dr. Roberts, Ladies and Gentlemen: I did not come with any prepared statement. I would just add confusion if I went back into the problems of this program. I happened to be on the AMA task force which worked with this program from the days following the passage of the law. I heard the hearings in the House and Senate concerning this law. I am acquainted with the background of the efforts to get a dependents' medical care program before this law came up. I think this law is probably as equitable a law to do the job as they could have gotten. The implementation of the law has been a little more of a problem, almost, than writing the law, which is usually true, particularly in this difficult field. I know, as Dr. Roberts has stated, that he would like to keep to the issues of the problem and not get off on extraneous details. I think the problem is what to do under this law now that it is here. The only alternative would be to go back to Congress and get it modified. I am open-minded to the fact that there are certain interpretations of the law. I think it is fair to say that the American Medical Association's representatives repeatedly and to this day did not think it was necessary to have a fee schedule in order to implement the law. How this could be worked out without a fee schedule and protect the interest of the government was not explored beyond the possibility of having a full fee schedule, a Schedule of Allowances, as they prefer to call it. This seemed to the negotiators for the Department of Defense task force to be the only way in which the government could determine its costs and appropriate its funds in order to meet this need. I do think it was the intent of Congress to give a service. During discussions of the early bills at the working level between the committees of the House, in particular, which framed the bill, Mr. Kilday's counsel went into the problems of insurance, of participation by the service man, of government programs, and of programs in industry. Out of all this came a bill in which the service man participates. As Dr. Robinson has indicated, sometimes he participates more than if he had an insurance policy; sometimes he participates less. It was considered to be more administratively feasible, of less expense to the government, a greater service to the man in building his morale and keeping the program in the proper frame, to have this type of partly participating program. I think the way the country has responded, the medical profession in particular, to meet this program has been remarkable.

"We had a meeting in Philadelphia following the Clinical Session. Dr. Milton, Dr. Roberts and others of your society are probably better able to discuss the results than I might be, but

it was a very harmonious meeting. There are still some states that are not certain how they are going to contract and work out this program. As Dr. Milton knows, I am sure, there are a number of states looking to you to see what you are doing. I will say that many people in other states are uninformed as to the facts of the case as it exists here in Florida, or as it exists in certain other states where the programs are not entirely of similar pattern. Very frequently, we hear stories and reports in Washington that come to us from people who have wrong information. I think the most important thing is to have the kind of briefings you have had this morning which bring to you again, for many of you have probably had them before, the true state of affairs, the facts as they are actually available now. I think I should conclude with this and offer my assistance at any time that any question may arise, and I congratulate you heartily on having the type of leadership you do in this program."

Dr. Roberts: "Members of the House of Delegates, we are almost finished with what your Association has prepared for you. We have one other man I want you to hear from because he comes from our sister state and I believe you will see that we are fair; we are trying to give you both sides of the issue. I would like to introduce to you now Mr. John D. Arndt, Medicare Administrator of the Medical Association of Georgia."

Mr. Arndt: "Doctors, I am currently the Medicare Administrator for the state of Georgia. As you probably found out from the presentation of General Robinson, we are our own fiscal agent; that is, there is no three party contract arrangement. The contract is strictly between the Medical Association and the Department of the Army. We receive all the claims forms; we process them, compile all the data, have our own Review Board, or Mediation Committee, and mail the checks or make disbursements to the doctors. There is no Blue Shield tie with the plan in Georgia. Our plan is mechanically working very well in Georgia, and we are satisfied we have a good arrangement from that viewpoint.

"With the forthcoming renegotiation, we are not satisfied with the fixed fee schedule—the maximum fee schedule. There are several reasons for this dissatisfaction: I think the primary reason is that the maximum fixed fee schedule is leading up to political or socialized medicine. For this reason, although the patients at this time are free to choose a physician and the physician has complete freedom of choice as to whether he wishes to attend a particular patient or not, as the base of people on a full coverage, national, fee schedule type plan expands to include a larger element of the American population, this freedom of choice will be removed from the doctors' hands. There will be so many patients under this type of plan that the doctor will no longer have a choice of accepting or rejecting a patient under it. That is what I consider the long run aspect of the plan and its end result. Currently, there are bills in Congress or committees to expand the Medicare full service coverage plan. One bill, I have been told, will include an additional 13 million people in that type of plan. The progress I think will continue in this direction. As you can see, 13 million people, with the existing people on the plan, will be about 15 per cent of our population. As this increases, you will lose your freedom of accepting or rejecting a full maximum fee schedule type plan.

"Georgia has not formulated its action on it at this time; that is why I am down here attending your meeting. I want to get some additional ideas and see what Florida is doing. We consider Florida the leading state in the Southeastern area, and I am down here for your guidance on the problem.

"I was very much interested in the statistics that General Robinson presented on the payments to the individual physicians. I should like to state that the trend is the same in Georgia. I would say that 125 doctors out of our 2,900 doctors receive 80 per cent of the $135,000 we disburse a month. These doctors are the ones who are not going to want this plan changed. I think, however, the important thing to consider is the long range aspects of it. Let us not sacrifice the dollar in the hand for later independence.

"Recently I conducted a survey of the 48 states to find out what other states' current thinking on the problem is. I received answers from 41 of them. The study produced some interesting statistics. Seven states indicated that they are not satisfied with the maximum fee schedule. They did not have at the time a counter-proposal other than merely stating they wanted to eliminate the fee schedule; they wanted to maintain our doctors' independence, or wanted an indemnity type schedule. That is about the picture in Georgia at this time."

Dr. Roberts: "I thank you, Mr. Arndt, for

those remarks. I am sure the House of Delegates appreciates your contribution."

Dr. Roberts asked Dr. Kennard and General Robinson to take seats on the rostrum for the question and answer session.

Dr. Roberts: "We put on our agenda a few items here, six in all, as a guide for the action of this House of Delegates. Without going into anything further, the House of Delegates represents the Florida Medical Association and we owe our members a great deal. We owe every member of the Florida Medical Association wise decisions and we have to have them in the records. We want them down in black and white. That is why we listed these items as a guide. We may not have to use them, but I think it would be well to go along with them.

"The first thing that I desire to have this House of Delegates decide is: Shall this Association continue to be a party to a contract with the Office for Dependents' Medical Care? If we can get that settled, I think our constituents back home, whom we are representing, will be satisfied with our decision. Let us get that done now, and if I can hear a motion on that, I would gladly entertain it."

The Chair recognized Dr. Richard F. Sinnott, delegate from St. Lucie-Okeechobee-Martin County Medical Society.

Dr. Sinnott: "I represent three counties, but only 27 doctors. I have come up instructed to mention first that our criticism of the Medicare program does not ignore our admiration for Dr. Milton, nor do we think that General Robinson means to socialize medicine. We believe they have endeavored to draw the best out of a bad situation. We think the situation is bad. Our criticism is of the whole philosophy of the Medicare program. I have been instructed to ask, how can we defend the granting of a full service contract to a full colonel and then deny it to a $125 a week telephone lineman? Second, why can there not be purchased by the government a major medical expense policy for ranks earning above the Blue Shield field? Further, I have been instructed to present this motion:

Resolution*
Medicare

WHEREAS: The Florida Medical Association is for (1.) Continuing to provide medical care for the dependents of men serving their country; (2.) Continuation of the free enterprise system in medicine with the right of a physician to set a just value on his own services, and (3.) The payment of a just salary to service men—one which would permit them to provide essentials for their families—including medical care.

WHEREAS: The Florida Medical Association is against: (1.) A fixed fee schedule as unjust, destructive of enterprise, by definition rigid and in practice unchangeable; (2.) A system which gives its recipients an illusion of "something for nothing;" (3.) A system which creates division within the profession already evident in committee and within the House; (4.) A system spelling out and enumeratng (like David taking the census) that which cannot be numbered "by the eighth inch", and (5.) A system previously designed by bureaucratic intent as essentially invasive and intended to rapidly comprehend the entire population.

BE IT THEREFORE RESOLVED: (1.) That the Florida Medical Association fulfill in good faith its present contract; (2.) That the Florida Medical Association enter into no new fixed fee contract with the Department of Defense; (3.) That the Florida Medical Association notify the proper authorities of its intent regarding non-renewal; (4.) That the Florida Medical Association assure the appropriate parties that its members will continue to provide good medical care to dependents and will submit, for the time being, individual bills to the Blue Shield as fiscal agent, and (5.) That the Florida Medical Association notify the Senators and Representatives from Florida that men serving their country in the Armed Forces deserve a just wage permitting them to provide their families the essentials including medical care.

Respectfully submitted,
Adrian M. Sample, Secretary
St. Lucie-Okeechobee-Martin County
Medical Society

*Not Approved

"I am further instructed to read back to Dr. Roberts what he sent us to read, a quote from George Washington: 'If to please the people we offer what we ourselves disapprove, how can we afterwards defend our work? Let's raise our standards to which the wise and honest can repair, the rest is in the hands of God.'"

Seconded by Dr. Cecil M. Peek, of Palm Beach.

Dr. Turner Z. Cason of Duval: "I would like to rise to a point of order. I understand this to be a motion on which, if we vote, we can get up and go home, because he proposes to answer all the questions and settle every difficulty. It is my understanding you asked for a motion on a specific item — No. 1. Now if we are voting on the whole matter, we can say goodbye and go on home. It seems to me rather out of reason, to say the least, to put in one motion the whole philosophy unless we are ready to vote on the whole subject at one time; if so, I am out of order. But I think that the motion is out of order at this time.

Dr. Robert E. Zellner of Orange: "Mr. President, before there is any discussion, it seems to me you will have to rule on this point of order. This is so comprehensive that it is not a motion; it is a series of motions. It seems to me that, before we can vote, you are going to have to rule as

to whether this motion is germane to the question, and, second, decide on whether we will vote on any parts of this motion. Before further questioning, I again ask for a point of order."

Dr. Jere W. Annis, of Polk: "I move that this be tabled."

Seconded by Dr. Cason.

Motion carried.

Dr. Roberts: "Now, No. 1 on your agenda. Shall I read this again? The Chair would like to entertain a motion: Shall this Association continue to be a party to a contract with the Office for Dependents' Medical Care?"

Dr. Langley: "I move that the Association shall continue to be a party to a contract with the Office for Dependents' Medical Care."

Seconded by Dr. Douglas and Dr. Bowen.

Dr. Sinnott: "I would like to ask someone to defend the idea of a contract when General Robinson mentioned that a noncontractual arrangement has been working so well in Ohio."

General Robinson: "I have asked to make a comment. I have told you that the program is working well in Ohio and Rhode Island and that our relations with individual physicians are good, but the medical associations in these two states have nothing to say about the standards of medical practice except as applied generally. They do not take an active part in the management of the program and they have nothing to say about whether or not the fee is reasonable. I do not think it is good for the state medical associations to take no active part in this program."

Dr. Kennard: "I would like just for information—this is just a fact—to say that while Ohio does not have a contract, there is a contract in existence with Mutual of Omaha to pay the bills, to act as fiscal agent in Ohio. The work that is accomplished by Dr. Milton's committee and by the committees of other states and their county committees, is being done by General Robinson's office. It's a fairly large job for his office. If other states relinquish their own contract and turn it over to the government and they form a contract with someone else, it will just build up this bureaucracy in General Robinson's office to do the work of deciding whether the physician's fee is equitable and just, whether he makes a fair claim. The feature of this whole thing is whether you want to keep control at the state level, or whether you want to pass this control to Washington. Under the bill, as it exists today, General Robinson is charged with furnishing this care through civilian sources and he has to make a contract with somebody."

Motion carried with Dr. Sinnott dissenting.

Dr. Roberts: "We will continue some kind of agreement with the Office for Dependents' Medical Care."

The Chair recognized Dr. W. Dean Steward of Orange County Medical Society.

Dr. Steward: "I move that the House of Delegates reaffirm its action of last May and continue to take care of dependents on a fee for service as previously agreed by the House of Delegates; also, that the contract be renegotiated yearly and that the contract may be terminated on 30 days' notice by either party."

Seconded by Dr. Madison R. Pope of Hillsborough.

Dr. Karl Hanson of Duval: "I would like to know whether that means that there will be no renegotiation of the maximum fee schedule which has been used during the past six months?"

Dr. Herschel G. Cole of Hillsborough: "As Chairman of the Hillsborough County delegation, I have been instructed to follow a similar procedure and recommend that negotiations be carried on and the contract be renewed without the maximum fee schedule, and in addition that the psychiatric group be included under this program as they have not been in the past. We are in favor of renegotiation without a fixed fee schedule."

Dr. Burns A. Dobbins Jr. of Broward: "Inasmuch as Broward County had a little something to do with this no fixed fee last time, I think I should say something at this time. A little knowledge about a problem can create much confusion. Many of you yesterday at the Blue Shield meeting realized that improving your knowledge of actual conditions helps understand the problem. I wish that I could express myself as eloquently as Bob Zellner did in saying that he was wrong 18 months ago about Blue Shield. I wish I could say how wrong I was five months ago. I did not understand all of the details of this contract, and our county society did not last spring when we brought it up to the House of Delegates. We were against set fees and we thought it could be done much cheaper otherwise, because we knew, as you know, that some of the fees are much higher than the average fee in the community. So we brought the matter up.

"Actually, as I understand the problems now, the Office for Dependents' Medical Care intended

all the time that the schedule would be maximum fees that would be allowable, that the state could adjudicate and pay without question; it was not intended to be the fee that was charged because it is their intent that this be carried on on a local basis and settled on a local basis in so far as possible, but that the maximum fee schedule is so that we can pay locally. Now that does not mean that there will not be greater fees paid if a special report is submitted and the extra charge justified. The government will pay more than the schedule and has paid more in the past, but as any of you know, the government cannot enter into a contract agreeing to pay just anything; it must know what the maximum will be that it will pay without question. That is the reason for the maximum fee schedule.

"I wish that Medicare could have a full day just like Blue Shield did yesterday, so that all of us could understand some of these problems a little bit more. The prime thing is that we want to control this as much as we can. We can do nothing about the law. We cannot say what is covered; the law specifically states what will be taken care of; Congress has taken care of that. It is up to us to try to represent the members of the Florida Medical Association to the best of our ability and see that their interest is taken care of. If we do not have a fee schedule, whether we want it or not, a schedule will be imposed at some level. If we have a schedule that we negotiate, we can do the membership a much greater service than we can by going into this thing blind and saying we will charge what we please."

Dr. Samuel M. Day of Duval: "I would like to ask a question. When this matter came up last spring, Dr. Milton and I were the only ones that threw out a word of caution: I withdrew mine later when it seemed that we could have a chance to prove a principle and allow the doctors to charge what they please. I found that I was thinking along different lines from what others were thinking. Certainly the information we sent out had a hint of what we thought or a direct statement of it. Our feeling was that if the doctors went along charging lower fees for the low income groups, which represent about 85 per cent, according to the way we are supposed to do with Blue Shield, and our private practices, then there would be some money left to charge the generals and the colonels more. Now, it turned out that it did not work because we did not do that, and then we find that some groups thought that the big counties were supposed to charge more and the little counties less; so that is another reason it did not work. There are two points there indicating why it did not work. We did not go along completely with it with the sincerity which we thought we might. I am not sure that it could be worked in that manner now. I would like General Robinson's answer to that—if we charged the lower income groups less, could we not charge the higher income groups more? Indiana has a plan whereby its over-all figure is supposed to average out. Say, an appendectomy should average at $150. If it is more than that the Medical Society of Indiana is supposed to pay the difference, and it is administering the plan. So, if we could have something where we could average out, it might work even better."

Dr. Zellner: "I would like to express a thought with reference to Dr. Steward's motion. In the first place, I do not think Dr. Steward disagrees with anything that has been said with reference to the fee schedule. We need not kid ourselves about this; irrespective of whether we vote for it, there will be a fee schedule. If we do not negotiate it, General Robinson will draw one up. In other words, as a taxpayer I would not be willing for the government to buy shirts on a basis on which it had not negotiated a per unit cost. It does not make sense. The sense of Dr. Steward's motion, as I understand it, is to continue the status quo. We have a fee schedule, whether you realize it or not, and we are having to use it. The importance of Dr. Steward's motion, I think, is this: If we negotiate a fixed fee schedule and publish it, everybody in the state is going to charge maximum fees. If we have a fee schedule and do not publish it, which is what we have now, and then send back the fees that do not conform to the schedule, then it leaves the matter in the hands of the local county medical society and the state, which I think is most important. It keeps the control where it belongs, not in Washington, not in Jacksonville, but in the local county society. As I understand Dr. Steward's motion, therefore, he wants to continue the same situation which we have, in which we will have to negotiate a fee schedule, changing various items in it, but it will not be published. That seems to me the most sensible approach, to continue to handle this matter on the lowest possible level."

Dr. James L. Anderson, of Dade: "I have been requested to speak about the neuropsychiatric schedule. It is not true that we are complete-

ly eliminated from participating in the Medicare program. I think it is that the statute regarding the compensation of neuropsychiatrists is somewhat unclear and ambiguous. It states that we can take care of acute emergencies. I think that it was the intent of the authorities involved to avoid prolonged hospitalization and prolonged psychotherapy, in so far as neuropsychiatric illnesses are concerned. The program, however, is not realistic in that it does not recognize the fact that about 80 per cent of our acute neuropsychiatric cases really turn out satisfactorily at the present time; that is, the patients are able to return to their homes and resume normal life. The few cases that I have had referred to me by Medicare have mostly been suicidal attempts necessitating shock therapy. Now, under strict interpretation of the law the period of hospitalization in such cases would be so limited that the psychiatrist would be in the position of taking care of the first few days of treatment and not being allowed to follow through on that type of case, whereas, if the patients could stay a few more days in the hospital, they probably would be over their depression entirely and able to go home a well man or woman. Actually, in practice what happens is that the brass just stated that the emergency was for that length of time and more or less told the hospital to pay the hospital bill for about four weeks; so we treated the patient until she got all right. Strangely enough, mental attitudes concerning neuropsychiatry have not improved to the point of burdening us with Medicare as far as the Army brass is concerned. For some reason or other, when we get visits from top echelon officers, and we do occasionally, the care definitely does not come under the Medicare program as far as the officers are concerned. They seem to want no record whatever made that it has to do with Medicare."

Dr. William M. Straight of Dade: "I would like to ask if the Department of Defense is adamant against the concept of paying a little higher fee for the 1 per cent who have an income above $9,000? I know from being in the Navy for three years, that when the brass gets sick, they get a better room in the sick officers' quarters and frequently have a private orderly or nurse waiting on them. They segregate them in the service. Why will they not pay us a little more in private practice?"

General Robinson: "Dr. Roberts has asked me to answer. I might say that at the time of the development of this program, the question was asked of the Congressional Committee as to whether or not there should be any leeway on charges to those in the higher ranks. I have been told by those who had to do with the development of the program that the Congressional Committee definitely made the statement that it wanted to run this program straight across the board for the majority of the people and that it wanted to include all ranks under the same provisions. Actually, it amounts to so little that it is hardly worth thinking about.

"Dr. Roberts, if I may, I would like to discuss the neuropsychiatric situation a little, too. Now, you know already that the law says that care for neuropsychiatric diseases is not included. It, however, also says that we will take care of all kinds of acute emergencies, and we do know that a great many of the acute emergencies occur in the neuropsychiatric field. So, we have lumped those all together and called them acute emotional disorders, and we have stated that acute emotional disorders are treatable for 21 days. This 21 days was not arrived at by any arbitrary means. A conference was held including all of the members of the group still left in Washington who had to do with the preparation of the Directive, the psychiatric consultants of the Army, the Navy, the Air Force and the Public Health Service and Dr. Overholser, who is the Director of St. Elizabeth's Hospital. We spent all afternoon devising a means of taking care of acute emotional disorders, and what came out of that meeting was ODMC Letter no. 8, with which I am sure many of you are familiar.

"We provided for extensions beyond this 21 days for three reasons. First, if the patient were having to be committed and her sponsor had to return from a battleship or Korea or some place which required more time than 21 days, an extension could be made. Second, if the patient were going to get well and be able to go back and assume her duties if she were kept a week or two weeks longer (a reasonable length of time), this extension could be approved. And the third reason was if there were difficulty in getting her into a state institution. We recognize that sometimes it takes longer than 21 days to get a patient transferred to the state institution. Now, we put the responsibility on the hospital administrator to get this additional authority.

"I know, you think you should not have to get the additional authority, but honestly, we

have to keep the program so it will pass the Comptroller General, and this is important. Consequently, we want the payments to be sound and to have approval so that they will not be questioned. The number of physicians who have furnished information for extensions is too few; they are just not doing it to the extent necessary. And, I would like to prevail upon all of you who have anything to do with the treatment of those afflicted with acute emotional disorders please to furnish necessary information when extensions beyond 21 days are indicated. We are changing the method of requesting extensions. We are leaving the responsibility with the hospitals, but we are letting the hospitals come direct to our office. Before we can approve one single day past 21 days, we have to go to all four Surgeon Generals and determine whether the patient can be taken in one of their facilities. That is just required. Psychiatric care is unauthorized care, and I think all psychiatrists, at least those to whom I have talked, think that even the 21 days, in a great percentage of cases, extends long over the period of an acute emotional disorder. I had one bill from a psychiatrist in Illinois, for example, who said he treated the patient for 40 days but that the government owed only for three days because her acute emotional disorder terminated in three days, and that the patient owed for the rest of the care.

"As soon as the new contracts are in effect, we will allow the hospital administrator to come direct to our office for extension authority in order to save time. We will try to have the answer back to the hospital before the 21 days is over. We, of course need the cooperation of the physicians caring for these patients."

Dr. H. Phillip Hampton of Hillsborough: "May I ask what you did in that case in which the doctor only charged you for three days and the patient for the rest of the time?"

General Robinson: "We paid for the three days; that is all he charged us for."

Dr. Hampton: "Was he justified in charging the patient?"

General Robinson: "Oh yes; it was unauthorized care. A physician is supposed to charge the patient for any care he renders which is unauthorized.

"Now, on the Indiana plan, which has been discussed, I have been to Indiana and I have seen how the plan is working. Actually, the Medical Society of Indiana had not approved many bills, when I was there, over the Schedule of Allowances. It had had several under the Schedule of Allowances. But, it has encumbered itself with a complicated bookkeeping system. For every item in the Schedule, it has to maintain a card, and it has to show the charge that it approves. It does not send in special reports. If, for any reason, it has a charge over the schedule, it may pay, but another charge which is less must have been paid in order to maintain a balance for each item. You can understand the necessary bookkeeping. I am sure that the Florida volume is so large that such a system could not be followed here with any reasonable staff.

"Now, then, as to whether or not you publish the schedule, as I said in my remarks, we have left this decision entirely to the states. The Schedule from the very beginning has been a maximum schedule. There are a sufficient number of doctors in Florida, and in all of the states, apparently, who are willing to take these cases, and I think this is very clear when 36 per cent of your physicians in Florida have already accepted cases.

"When the dependent goes to the doctor, she should ask him if he will take her case under the Dependents' Medical Care Program. If the doctor does not desire to accept the allowance, we think he should refer her to someone who will take her case and give her good service. On the other hand, you may have more than one Schedule of Allowances if you desire. We made this known before the first negotiation. If you want to have six maximum Schedules of Allowances to cover various areas of Florida, we would not oppose. No state, however, has submitted such a plan. It is probably impossible to cover what specialists will get, what general practitioners will get, what resort area physicians will get, what physicians in rural areas will get, all in one Schedule of Allowances. Therefore, it was thought that the best thing to do is to have a reasonably liberal maximum Schedule of Allowances and let you control that which is normal for individual physicians. Those physicians who are submitting bills which you know are not normal fees in their practice, we hope you can somehow control. This cannot be done by our office because we do not have the knowledge."

Dr. Kennard: "I concur with what General Robinson said about the intent of the committees that considered the problem of the lower income and the higher income military personnel. Mr. Kilday, the chairman of the committee, for whom

this bill is often named, recognized that this would create a question for the profession. It was, however, the consensus of the members of the committee when it was considered that they could not make an exception. There has been for 150 years or longer, since the first military establishment had a form, some form of care for dependents of military personnel. The earlier bills presented to Congress, which we opposed very vigorously from 1945 on, were bills to provide care completely in military facilities, to expand military hospitals and the military medical corps to take care of all military personnel in those facilities. One of our biggest objections was the fact that they were drafting doctors, and might have to for some time, or at least encourage them to come in the service to take care of a large number of dependents. So, we asked them to put this extra work load, this 40 per cent for which this bill was designed, into civilian facilities on a basis similar to that provided in military facilities, and that is where your leveling out influence counts.

"Personally, having been a military man for 26 or 27 years, I think the brass, or the majority of them, will go to military facilities where they get special care. There are going to be exceptions to this. I know that many of you have had colonels' and probably generals' dependents come to you for care, but these are the exceptions.

"I do not think you have very much of a problem here except on the basis of principle. I can say just one word about principle. This bill, this program, actually has, and I will not categorically say it is not going to have, some influence upon other forms of medical care. It was, however, designed to accomplish one specific purpose and in this respect it is different from the indigent care program, which is a big problem, the federal civil employees program which is coming up in Congress, which is on another basis and is a different problem, and the Forand bill, which was referred to by one of the earlier speakers. I surely hope we get out and fight the Forand bill with everything we have because here we really have the first step in socialized medicine. In this proposal, we have a compulsory health insurance plan for the 13 million over age 62 or 65, and it can be extended. These are different programs and they should not be confused with this one. That is the problem, not to bring this program into the picture and focus attention upon it as a solution to these other problems, because it is not the same thing."

Dr. Robert L. Tolle of Orange: "Bascially, I am opposed to closed sessions and being kept ignorant. I see no good reason why the schedule should not be published so that we will know where we stand. That does not prevent those who would charge less, if they are basically honest anyhow, from charging what they would normally charge. I am heartily in favor of knowing where we stand in regard to what is considered an equitable fee as far as the Defense Department is concerned."

Dr. Henry L. Harrell of Marion: "Since the figure was quoted that about 97 per cent of us kept using this fee schedule after July 1, I wonder if all of our members would not like to have this maximum fee schedule kept published and also would it not take much load off our state association and its constituent members?"

Dr. Anthony C. Galluccio of Broward: "We know there is free choice of physicians. Now with reference to the large amounts paid to the small number of physicians, is there any explanation for that other than physical proximity of physicians to large numbers of Medicare dependents?"

General Robinson: "If I understand the question, are you referring to the ranges that have been paid?"

Dr. Galluccio: "Yes."

General Robinson: "I do not know where they are located, Sir, nor who they are. The information was obtained from cards punched by Blue Shield and furnished to us. We do not have the names of the physicians to compare with the card numbers."

Dr. Straight: "At the risk of being repetitious, I would like to talk a little more about getting a different fee schedule for those people in the services who have incomes ranging above $4,300. I do not think there are many people in this room who are deluded to the point that they do not believe this is the beginning of a gradual socialization of medicine in this country. If, as time goes on and more and more employees of the government get pulled into schemes such as this, which I think we will have to accept gradually because we will have no choice, there will still be some of the poor who do not work for the government whom we will take care of with very little or no remuneration. At present, we make up the loss we take on these charity patients or near charity patients by better fees from those who can afford to pay. As the present pattern expands into more and more of a social system, we will not have that source to fall back on to recoup

our losses. I still think that some effort ought to be made to get the provision in our agreement that for those people who have a better than average income should pay a little higher for our services, if only as a pattern or policy for the future because it seems this is only part of a program to change us gradually to government physicians."

Dr. Hampton: "I think it is time to ask for the question, and in order to answer some of these remarks that have been made, I believe the best economic system of medical payments for the physicians must be the one that provides the best medical care for the patient most economically. The crux of the matter as to whether this plan is going to lead to socialized medicine or not is whether the civilian care that these patients have the freedom to choose will provide better medical care more economically. I would, therefore, like to ask three questions of General Robinson to determine whether perhaps the law is so rigged that it will not favor civilian medical care. 1. Why is the patient not required to pay the first $25 of hospital care costs in military hospitals? Is this $25 payment fixed by law or by regulation? 2. Are there any estimates of the cost of dependents' care in military hospitals? 3. What is the percentage of dependents hospitalized in civilian hospitals at this time as compared to those hospitalized in military facilities? I realize that this may be off the motion at this time, and if you think it would be better for these questions to be asked later, I will certainly understand."

Dr. Roberts: "I will have to rule that they are to be answered later."

Someone asked: "Does that include nonpublication of the list?"

Dr. Roberts: "That is not in the motion. I want to ask Dr. Steward if he intended to include in his motion item No. 4 on the agenda: 'If no fixed fee is to be in effect,' in other words as we are going now, status quo, 'shall the Association accept the government's policy of adhering to a maximum fee schedule?' The status quo would be what we are doing now. That would be in order in your motion?"

Dr. Steward: "At each renegotiation, if the government is going to say that this is a maximum, each of these cases would have to be considered individually for each area in my opinion. I think it should be done at the county level."

Motion was read again.

Motion carried.

The Chair recognized Dr. Steward.

Dr. Steward: "I move to empower the Medicare Committee to renegotiate a fee schedule as a guide for state and county committees to use in going over the fees submitted."

Seconded by Dr. Zellner.

Dr. Gretchen V. Squires of Escambia: "I would like to ask Dr. Steward if he would consider an amendment to that in which the state schedule be subdivided on the basis of districts for easier use by the local Medicare committees, since there are such wide variations in fees in various sections of the state."

Dr. Roberts: "Do you accept that, Dr. Steward?"

Dr. Steward: "No, sir, because what will be set up will be a maximum schedule. Each local committee in each district is supposed to adjust the fees according to what is generally charged in that area. I can not see where separate schedules would be necessary."

Dr. Melvin M. Simmons of Sarasota: "I would like to ask Dr. Steward if he will accept substitute wording to make that a 'maximum schedule of allowances' rather than a fee schedule—to change the wording to a 'schedule of maximum allowances' as a guide?"

Dr. Steward: "I accept that."

Dr. Day: "I would like to clarify a little bit —if an individual doctor writes the office for a copy of this schedule, are we to give it to him?"

Dr. Roberts: "How can you refuse?"

Dr. William R. Ploss of Monroe: "I believe the proper answer to an individual requesting such a fee schedule would be to refer him to his own county society, if those copies are available on a local level."

Dr. Day: "That is what we would like to have clarified."

Motion carried.

The Chair recognized Dr. Dobbins.

Dr. Dobbins: "My county has asked me to introduce this resolution."

Resolution
Local Medicare Committees

WHEREAS: It is the intent of the Florida Medical Association that medicare fees be determined and administered on a local basis.

BE IT RESOLVED THAT: The Florida Medical Association urge each of its component county societies to establish a strong local committee which will acquaint itself with medicare and administer medicare affairs on a county basis insofar as possible.

BE IT FURTHER RESOLVED THAT: In the absence of a local committee the Florida Medical As-

sociation empower its Medicare Mediation Committee to determine fees based on local standards.

Respectfully submitted,
Garland M. Johnson, Secretary,
Broward County Medical Association

"I move the adoption of this resolution."

Seconded by Dr. Jack L. Wright of Dade.

Dr. Sinnott: "As a member of a small county society, I would like to object to any coercive instructions from the state society to a county society."

Dr. S. Carnes Harvard of Pasco-Hernando-Citrus: "I do not see from this resolution where these local county levels are going to set up fees for that particular small county or large county; I do not see where that would be equitable."

Motion carried.

Dr. Roberts: "Next, we must select representatives for the negotiation of a contract in January. I want you to know that is soon. How shall we go about it?"

Someone asked: "Who is the present committee?"

Dr. Roberts: "John Milton."

Dr. Milton: "As I told you, I did not want to be chairman of the negotiating team this time. According to regulations already sent out by ODMC, there will be two negotiators paid by ODMC. Any others will have to be paid by the state association."

Dr. Zellner: "I can appreciate Dr. Milton's desire to get off this committee, but this is still a new baby, and I do not see how we can afford to let him go. It seems to me, therefore, that it is a foregone conclusion that we are going to have to ask him to do it again. Now there is one item that needs more thought, and that is the medical section of the schedule. If nominations are in order therefore, I would like to nominate Dr. Donald Marion as the second member of the negotiating team, if for no other reason than to have him learn how this is going so that if Dr. Milton insists on quitting, we will have another good man to carry on."

Dr. Hampton: "I second both nominations."

Dr. Roberts: "Do I get your nomination straight, Dr. Zellner? Do you presume that Dr. John Milton has been nominated?"

Dr. Zellner: "I presume he has no choice."

Dr. Roberts: "Are there any other nominations for chairman of this negotiating team?"

Someone asked: "Who is nominated?"

Dr. Roberts: "Dr. John Milton."

Dr. Hampton: "I move that nominations be closed."

Seconded by Dr. Dobbins.

Someone in the audience said: "That was not chairman, was it? Dr. Zellner just nominated two men for the nominating team."

Dr. Roberts: "Will you give the Chair the prerogative to appoint him?"

Dr. C. Robert DeArmas of Volusia: "Is it possible to have more than two on that team?"

Dr. Roberts: "Two only will be paid by the government. You can have as many others as you want."

Dr. DeArmas: "I would like to nominate Dr. Judson Graves."

Dr. Roberts: "Did you understand Dr. Milton's remarks? If you have more than two negotiators, that the Florida Medical Association will have to bear the expense?"

Dr. Hampton: "I rise to a point of order. There was a nomination on the floor that has been seconded that after the first two nominations, nominations be closed. I would suggest that we vote on that and then if there are additional nominations they can be acted on."

The Chair called for a voice vote which was inconclusive. Dr. Roberts then called for a standing vote.

Motion carried.

Dr. Hampton: "I would like to suggest that if anyone wishes to nominate other members to the negotiating team at their own expense or at the Florida Medical Association's expense, that be done."

Dr. Roberts: "I would be glad to entertain such a motion, but if you make a motion, you should stipulate whether the FMA pays or whether the man himself pays. The Board of Governors has to know these things."

"Are there any other nominations?"

Dr. DeArmas: "I would like to nominate Dr. Judson Graves of Jacksonville to go at his own expense."

Dr. Herbert W. White of St. Johns: "I would like to nominate Dr. Burns Dobbins of Broward County."

Dr. Steward: "If it is possible to amend this motion, I would like the Florida Medical Association to send at least one of these men. I do not think it is fair to nominate a man and ask him to pay his own expenses."

Dr. Roberts: "Will you accept that amendment?"

Dr. DeArmas: "Yes."

Dr. Jere Annis: "Before we keep nominating,

I think we should decide how many we want on this negotiating team. Let us set a limit."

Dr. Cecil Peek: "I nominate Dr. Leo Wachtel."

Dr. Zellner: "It seems to me some decision should be made as to how many are going. If we can amend this motion once more, I would like to amend it that we send one more to be elected from the ones nominated, expenses to be paid by the Florida Medical Association."

Dr. Walter E. Murphee of Alachua: "I move that Dr. Zellner's motion be a substitute motion so that we can vote on it first."

Seconded by Dr. Hanson.

Motion carried.

Dr. Roberts: "Dr. Zellner, will you clarify the motion that just has been passed so that everybody will understand."

Dr. Zellner: "The motion was that we send one additional negotiator whose expenses will be paid by the Florida Medical Association, to be selected from those nominated."

On motion, duly seconded and carried, nominations were closed.

Dr. Squires asked for the specialties of the nominees.

Dr. Roberts: "Dr. Wachtel specializes in diseases of men, women and children; Dr. Dobbins specializes in diseases of those under 15 or 12; and Dr. Judson Graves is a radiologist."

The Chair asked for a standing vote for the nominees:

Dr. Leo Wachtel—19

Dr. Burns Dobbins—46

Dr. Judson Graves—17

Dr. Roberts: "Dr. Dobbins will be your paid delegate."

The Chair recognized Dr. Russell B. Carson, President of Blue Shield.

Dr. Carson: "I am a visitor, but I do not see on the agenda the selection of a fiscal agent and I am wondering if you are desirous of continuing Blue Shield or shall we be relieved of our duties?"

Dr. Roberts: "I am very thankful to you for suggesting it, Dr. Carson. Will some member of the House of Delegates talk about that?"

Dr. Harvard: "I move that Blue Shield be kept as our fiscal agent."

Seconded by Dr. Eugene G. Peek Jr. of Marion.

Motion carried.

Dr. Douglas: "May I present a foreign motion, so to speak? The delegates from Escambia County wish to present the following motion in regard to antepartum care: that the House of Delegates of the FMA officially approve the principle of payment for each antepartum visit rather than by trimesters, that the drugs allowed under the Medicare program be obtained by the patient from the pharmacy of her choice and that the pharmacist be paid directly by the Medicare program under a plan similar to that used by the Veterans Administration for payment for drugs."

Seconded by Dr. Herbert L. Bryans of Escambia.

Dr. Murphree: "I move that resolution be referred to the negotiating committee."

Motion seconded.

Dr. Douglas: "I will be very glad to accept the motion that it be referred to the negotiating committee to save time."

Motion carried.

Dr. Hampton: "I rise to ask whether that resolution is referred without approval or rejection?"

Dr. Roberts: "It is referred to them, I presume, for their consideration and to do the best they can do with it."

Dr. Douglas: "Is that dropped now? I wanted to explain why I brought it up."

Dr. Roberts: "Go right ahead."

Dr. Douglas: "The General has pointed out that there will be a choice in the handling of antepartum care. We think that is one of the big criticisms of the entire system in our part of the state. If antepartum care is paid for by visits, we believe the fee will be much more just."

Dr. Roberts: "I think it was understood when General Robinson talked about antepartum care that you have to take one or the other. I am sure the negotiating team would like to have an expression from the House as to whether you prefer to take it on a trimester basis or on a fee for service basis. It will help the committee members make up their mind and will give the doctor what he wants. We can take one or the other, but we cannot take them both. I think it is a good question.

"Now, you want an expression from the House of Delegates; is that what your motion intended in the beginning?"

Dr. Douglas: "Mr. President, I simply wanted it down in writing, the fact that it is a question. I do think that the three man group can very

ably handle the problem, and I see no particular reason for discussion.

Dr. Milton: "In May, your committee in reference to the schedule made this particular recommendation to the Reference Committee that we have a fee for service and on the strength of that, the Office for Dependents' Medical Care has been contacted."

Dr. Rowland E. Wood of Pinellas: "I would like to move that the House of Delegates adjourn and any matters that have not been brought up be referred to the three man committee."

Motion seconded.

Dr. Roberts: "I want to beg your motion just a little bit, Dr. Wood, to give Dr. Hampton a chance to ask a question here that we think is germane to our whole setup with reference to Medicare."

Dr. Hampton: "I have asked three questions of the General as further information to the excellent presentation of the studies that have been made of this plan so far, to try to point out that we have been quite concerned about fee schedules and certain principles, but perhaps some of us have overlooked what I think is the basic issue. This is an opportunity for a certain segment of the population in this country to choose government care or civilian care. I think it is an excellent opportunity. I think it has been fairly presented, and I wanted to ask three questions to see if these patients actually have free choice, and if they may be influenced by other factors than actually the best and most economical care that they can get. I have, therefore, asked these three questions of General Robinson.

"1. Why is the patient not required to pay the first $25 of his hospital costs in a military hospital, and is this $25 payment to a civilian hospital the law, or is that the regulation?

"2. Are there any estimates of the cost of dependent care in military hospitals?

"3. What percentage of dependents of the military are now choosing civilian hospital care and what percentage are choosing military hospital care?"

General Robinson: "You have asked questions that are unanswerable.

"Why the $25 was put on the civilian program and not on the military program, I cannot positively say. This was determined before I had anything to do with the program. I would imagine the decision to charge $25 was probably made to act as a control to keep down unnecessary hospitalization in civilian hospitals.

"In service hospitals, we do not have quite the need for such controls that you have in civilian medicine because we control it through command. I am sure this is the reason.

"The estimates of costs in military hospitals came up in Congressional appropriation hearings last year. The committee was of the opinion that costs in military hospitals were considerably less than in civilian hospitals. I have already showed you our best estimate of what this program is costing. The Appropriations Committee wrote into their report that consideration should be given by the Defense Department to making limitations in areas around military hospitals for economy reasons. That was advised against by our office, the A.M.A., and the American Hospital Association. Nothing has been done to establish such restrictions at this time. We have recommended that consideration be given to employing a statistical agency to determine what comparable costs are. There really are no existing comparable figures. I think probably the civilian program will cost more, mainly because in our hospitals we have command control, and theoretically a more economical program should result. Also, it is rather generally recognized that civilian physicians are better remunerated than military. These two generalizations would lead to the conclusion that care in uniformed services facilities would be somewhat less expensive.

"As to the number of military and civilian patients, I have already told you we are running more than 4,000 patients a day in the civilian program. I might be able to make a 'guesstimate' as to how many we are running in the military program, but I would say that it might be about 7,000 or 8,000 a day.

"Between the two programs, in spite of the fact that the military services have come down in strength, in the year that we have been in operation, 35 per cent more dependents are being cared for than last year.

"May I just say, since this will be my last appearance, I have enjoyed very much coming to Florida and working with you. I assure you that we do not know all the answers to all questions concerning the program at present. We are going to continue to do our very best to resolve the questions as they arise. We hope the manual which we have prepared will do much to create better understanding. Whether or not you

enter the fees which we negotiate in the manual, we are going to ask you officially to publish it at government expense, so that every physician has a copy."

Dr. Hampton: "Thank you, General Robinson, for those statistics. I take it that it is running about two to one, the utilization of this program, in favor of military hospitals. There are approximately two patients to be cared for in military hospitals to one in civilian."

General Robinson: "That is very rough; you understand that."

Dr. Hampton: "I would like to ask further then whether that $25 the patient is required to pay is the law or the regulation?"

General Robinson: "It is the law."

Dr. Hampton: "It is the law. It seems to me that that is definitely weighing the balance in favor of military hospitals in the patient making his choice as to whether he will be hospitalized in civilian or military hospitals. I think that $25 is an unfair weight in this plan in favor of military hospitals. We have heard it stated that 2 per cent of the patients are stating that they would not choose civilian hospitals again. Obviously, if over the period of the next five or six years more and more patients choose military hospitals, it would be a very strong factor for the development of more government medical care. This is a challenge to the civilian physicians and civilian hospitals to provide better medical care for dependents of military personnel, and we must show that it can be done more economically, in addition to being better. This $25 is a very strong factor in the patient's mind in choosing between civilian and military hospitalization, but I somewhat doubt, General, that the position of the civilian physician and that of the military physician differ much as far as the patient's desire to go into a hospital is concerned. I think it would be just as much a deterrent factor for the patient to go into the hospital unnecessarily in a military hospital as it would for him to go unnecessarily into a civilian hospital.

General Robinson: "There may be other reasons; I just don't know."

Dr. Hampton: "I wonder if it is possible for us to make strong recommendations that the $25 be charged the patient who goes into a military hospital."

Dr. Kennard: "I can add one further clarifying comment. This $1.75 a day happens to be the present rate. The law provides the following: 'For each admission, the plan shall also provide for payment by the patient of hospital expenses incurred under paragraph 1 hereof, in the amount of either (1) $25 or (2) the charge established pursuant to Sec. 103-C of this act multiplied by the number of days of hospitalization.' Section 103-C states: 'The Secretary of Defense after consultation with the Secretary of Health, Education, and Welfare shall establish fair charges for in-patient medical care given dependents in the facilities of the uniformed services, which charges shall be the same for all dependents.' The Secretary of Defense has it in his capability, in the law, to set the fee at anything above or below $1.75 a day. This is something that can be dealt with with him."

Dr. Hampton: "In other words, he could say that the first day would be $25 in a military hospital if he wished, or the first five days would be $5?"

Dr. Kennard: "That is right. He could establish a different rate. It does not take any law; he has the authority here to equalize it if that should be appropriate."

Dr. Hanson: "There is a motion before the House."

Dr. Roberts: "Before we call for the vote on that, Dr. Tolle, did you want to say something?"

Dr. Tolle: "Yes, there is one other thing. We are dealing now with General Robinson, who is extremely cooperative, but I was wondering, what provision there is, since there is so much authority wielded by his office, for replacing the Executive Director in case he is dictatorially inclined and we are unable to get along with him."

General Robinson: "I think you can expect that there will always be excellent personnel in the office."

Dr. Roberts: "We will have that 30 days' grace anyhow."

Dr. Roberts: "This is the House of Delegates, and I do not want anybody to go home unhappy."

Dr. Edwin W. Brown of Palm Beach: "I just wanted to say that I think we should all be reminded that our government is for the people and by the people and that we doctors are the people. In a sense, we are negotiating with ourselves. We are paying from one pocket into the other. We would like our cost of government to be reduced, that the budget be balanced, that our taxes be reduced. We are dealing with largely a lower income group of people in the Medicare program

and we would like the Medicare program to be as low as possible."

Dr. Roberts: "We had seated today 101 delegates out of 155; 78 were required for a quorum. Now, I want to take this opportunity to thank this House of Delegates, first, for coming, for being here. You are the people who are definitely interested in organized medicine. About those fishing friends, who could not bother to come up here on the weekend, I shall have something to say later on, probably in my annual address. I want to thank you from the bottom of my heart for being brainy and learned men, and men of statesmanlike qualities. You did not confuse me too much. Fortunately, the gods were with me since my parliamentarian did not come. I thank you for your kindness.

"I want to thank General Robinson and Dr. Kennard for coming and I want to thank Mr. Arndt; we appreciate your interest. If nobody objects, Dr. Woods motion is in order; it will not require any discussion."

Motion carried.

Meeting was adjourned at 1:10 p.m.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 2411 JACKSONVILLE, FLORIDA

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Program for Eighty-Fourth Annual Meeting

The program for the Eighty-Fourth Annual Meeting of the Florida Medical Association at the Americana Hotel, Bal Harbour, Miami Beach, May 10-14, 1958 has been arranged to follow the plan of last year's successful meeting. The scientific sessions and the organizational work of the Association have been arranged to avoid conflicts. The majority of the scientific papers have been scheduled on one day to permit members who find it impossible to attend the full session to come on Tuesday. The work sessions of the House of Delegates have been spread so that adequate time is available between the sessions for hearings of reference committees; the time is not interrupted by other meetings.

The activities of the speciality groups are planned for Saturday and Sunday. The first session of the House of Delegates will convene in midafternoon Sunday. The General Session on Monday will include, in addition to talks on organizational aspects of medicine, two general scientific talks. Outstanding out-of-state speakers have been obtained to review the up-to-the-minute status of such subjects as the relation of tissue specificity to surgical transplantation of organs and the changing concepts of tuberculosis. It has been impossible to schedule for the Association's program all of the distinguished visitors who are speaking at the meetings of the special societies. The popular panels will be continued this year on Tuesday and will cover both medical and surgical aspects of chest diseases and recent advances in modern methods of diagnosis and therapy. The remaining scientific sessions will be devoted to the specialties and to surgery. The second session of the House of Delegates on Wednesday will conclude the meeting.

The Scientific Exhibit will feature health evaluations for physicians attending the meeting. The Committee on Tuberculosis and Public Health of the Association, in conjunction with the Woman's Auxiliary, State Board of Health, and the Medical Schools of Florida, will conduct physical examinations, run screening laboratory procedures and have experts to interpret them for busy physicians while they wait. Though physicians recommend these periodic evaluations for their patients, few take the time from practice to have

themselves examined. A special exhibit on accidents has been arranged to emphasize the increasing importance of this useless waste of life. The hotel has built a new exhibit hall so that more space is available under better circumstances for display of scientific material than has been possible in recent years. A few spaces are still available for new exhibits.

The program of motion pictures and kinescopes planned for Monday evening still has a few openings.

The program allows adequate opportunity for a balance of scientific postgraduate education and much needed rest and relaxation. The hotel is cooperating to the fullest in planning the use of its beautiful facilities for an excellent meeting.

Association Policies on Medicare Determined at Called Meeting Of House of Delegates

Medicare was the subject of a special meeting of the House of Delegates of the Florida Medical Association, held at the George Washington Hotel in Jacksonville on Dec. 8, 1957. Of the 155 delegates eligible to participate in the called meeting, 101 were seated, and other members of the Association were present.

Dr. John D. Milton, who has served as chairman of the Association's Medicare Mediation Committee from the beginning and is thoroughly conversant with the Medicare Program, was the first speaker. He presented a comprehensive review of Medicare in Florida. Among the several guests who were in attendance were three who addressed the House. Major General Paul I. Robinson, Executive Director of the Office for Dependents' Medical Care, Washington, D. C., presented the current over-all picture of Medicare and in the question and answer period was most cooperative in elucidating many aspects of the Medicare Program. The Assistant Director of the Washington Office of the American Medical Association, Dr. William J. Kennard, Washington, D. C., discussed several facets of the subject. Mr. John D. Arndt, Medicare Administrator of the Medical Association of Georgia, Atlanta, Ga., explained the handling of the Medicare Program in Georgia. Blue Shield of Florida was represented by Dr. Russell B. Carson, President, Mr. H. A. Schroder, Executive Director, and Mr. N. G. Johnson, Medicare Coordinator.

The House voted to continue to be a party to a contract with the Office for Dependents' Medical Care. It reaffirmed its action of May 1957, which was to continue to provide authorized professional care for eligible dependents on a fee for service basis, accepting the policy of the government that the Schedule of Allowances shall be a maximum for all fees not substantiated by special report.

The FMA Medicare Committee was empowered to renegotiate a maximum Schedule of Allowances as a guide for the Association and county medical society Medicare committees. The negotiating team authorized by the House to represent Florida at the first of the renegotiation conferences, scheduled to be held in Washington on Jan. 6-7, 1958, was Dr. John D. Milton, chairman, of Miami, who was drafted to continue in that capacity, Dr. Donald F. Marion, also of Miami, and Dr. Burns A. Dobbins Jr., of Fort Lauderdale.

It was emphasized in the discussion leading to the House actions that the fees charged eligible dependents under the Medicare Program should be those usual to the community, that all authorized care is on a full service basis, and that persistent charging to the maximum could encourage the Office for Dependents' Medical Care to request a re-evaluation of the maximum Schedule of Allowances.

The House accepted with appreciation Blue Shield's offer to continue as the Fiscal Administrator of the Program in Florida.

The complete proceedings of this called meeting of the House are published in this issue of The Journal.

Seminar on Cardiovascular Diseases Jacksonville, February 20-22, 1958

The Fifth Annual Seminar on Cardiovascular Diseases will be presented by the Northeast Florida Heart Association on February 20, 21 and 22 at the Prudential Auditorium in the Prudential Building in Jacksonville. Co-sponsors of the meeting are the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida State Board of Health and the Florida Medical Association. The Seminar is endorsed by the Florida Heart Association and is accepted by the American Academy of General Practice for 15 hours' credit in Category I.

The outstanding faculty includes such distinguished teachers as Dr. Samuel Bellet, Professor of Clinical Cardiology, University of Pennsylvania

Graduate School of Medicine, Philadelphia; Dr. George E. Burch, Professor and Chairman of the Department of Medicine, Tulane University School of Medicine, New Orleans; Dr. Denton A. Cooley, Associate Professor of Surgery, Baylor University College of Medicine, Houston; and Dr. Ben I. Heller, Professor of Medicine, University of Arkansas School of Medicine, Little Rock. Local faculty members are Dr. James E. Cousar III, Dr. Lawrence E. Geeslin, Dr. Karl B. Hanson and Dr. Joseph J. Lowenthal.

Registration will begin at 8:30 a.m. on Thursday, February 20. The registration fee is $10, with no charge for residents, interns and physicians in the armed services. A special parking area will be provided for those in attendance. On Thursday and Friday, luncheon groups will meet in the St. Johns Room in the Prudential Building. The Roosevelt Hotel will be the downtown headquarters, and reservations may be secured by contacting the hotel or the Northeast Florida Heart Association, 425 W. Duval St., Jacksonville.

At the opening session on Thursday morning, Dr. Turner Z. Cason, President, will welcome the registrants and guests. Dr. Daniel R. Usdin, Chairman of the Program Committee, will preside, and the other members of this committee, Dr. J. Brooks Brown, Dr. David R. Moomaw and Dr. Richard A. Nelson, will preside at succeeding sessions. On Friday morning, Dr. Simon D. Doff will preside.

The program follows:

FIFTH ANNUAL SEMINAR ON CARDIOVASCULAR DISEASES PRUDENTIAL BUILDING, JACKSONVILLE, FEBRUARY 20-22, 1958

THURSDAY, FEBRUARY 20		Presiding: Dr. Daniel R. Usdin
8:30	Registration	
9:20	Address of Welcome	Dr Cason
9:30	"Electrolyte Disturbances in Congestive Heart Failure, Part I"	Dr. Heller
10:05	"Electrolyte Disturbances in Congestive Heart Failure, Part II."	Dr. Heller
10:40	Recess	
11:00	"Cardiac Arrhythmias"	Dr. Bellet
11:35	Panel Discussion: "Arrhythmias and Electrolytes"	Drs. Heller, Bellet, Hanson
12:30	Lunch	
	Presiding: Dr. David R. Moomaw	
2:00	"Pericarditis with Effusion"	Dr. Bellet
2:35	"Cardiac Complications in Renal Failure"	Dr. Heller
3:10	Recess	
3:25	"Cardiac Arrest"	Dr. Bellet
4:00	Clinical Conference: "Cardiovascular Problems" Moderator: Dr. A. Sherrod Morrow	Drs. Bellet, Heller, Geeslin
FRIDAY, FEBRUARY 21		Presiding: Dr. Simon D. Doff
9:00	"Correctable Forms of Hypertension"	Dr. Burch
9:35	"Management of Patients with Hypertension"	Dr. Burch
10:10	Recess	
10:30	Panel Discussion: "Hypertension" Moderator: Dr. George T. Harrell	Drs. Burch, Cooley, Heller, Bellet, Lowenthal
11:30	"Surgical Aspects of Arterial Occlusive Disease"	Dr. Cooley
12:30	Luncheon Conference "Medicine and Russia," Dr. Burch	
	Presiding: Dr. J. Brooks Brown	
1:30	"Surgery of Aortic and Arterial Aneurysms"	Dr. Cooley
2:20	"Interesting Aspects of the Aging Process"	Dr. Burch

2:55	"Open Heart Surgery—Results in 300 Patients Using Pump Oxygenator"	Dr. Cooley
3:40	Recess	
4:00	Panel Discussion: "Heart Surgery" Moderator: Dr. Arthur R. Nelson	Drs. Cooley, Burch, Bellet, Cousar

SATURDAY, FEBRUARY 22 Presiding: Dr. Richard A. Nelson

9:00	"Chronic Renal Disease"	Dr. Heller
9:35	"Coronary Artery Disease"	Dr. Bellet
10:10	Recess	
10:30	"Unusual Problems in Cardiovascular Surgery"	Dr. Cooley
11:05	Question and Answer Period	Drs. Heller, Bellet, Cooley

Symposium on Cardiovascular Problems Of the Aging

Miami Beach, April 12, 1958

A symposium by outstanding experts on the Management of Cardiovascular Problems of the Aging is being sponsored by the Dade County Medical Association in conjunction with the J. B. Roerig Company on Saturday afternoon, April 12, 1958 at the Eden Roc Hotel in Miami Beach. All members of the Florida Medical Association are invited to attend.

Dr. O. Whitmore Burtner, Chairman of the Symposium Committee, has announced that the titles of the three papers planned for this afternoon symposium are: Peripheral Vascular Disease, Cerebral Vascular Insufficiency and Emotional Aspects of Coronary Disease. The names of the four speakers who will participate will be announced at an early date.

A cocktail party at 12 p.m., in the Imperial Room of the Eden Roc Hotel, will be followed by a luncheon with a guest speaker in the adjoining Pompeii Room. The luncheon speaker is expected to touch upon some of the lighter aspects of lipid metabolism. The three papers will then be presented. A question and answer period will end the meeting at about 5 p.m.

The wives of the members of the Florida Medical Association will be invited to the cocktail party and the luncheon. Entertainment will be provided for them in the Mona Lisa Room of the hotel while the symposium is in session.

Second Annual Fracture Course Chicago, April 16 - 19, 1958

The second annual Post Graduate Course in Fractures and Other Trauma will be given by the Chicago Committee on Trauma of the American College of Surgeons, for four days from Wednesday, April 16 through Saturday, April 19, at the John B. Murphy Memorial Auditorium, 40 East Erie St., Chicago.

All phases of trauma will be discussed by outstanding teachers from five medical schools, and chiefs of services of leading hospitals in the Chicago area as well as notable guest speakers from other parts of the country. Among the visiting guest speakers are Dr. Walter Blount of Milwaukee, Dr. H. Relton McCarroll of St. Louis, Dr. Don O'Donoghue of Oklahoma City, and Dr. Joseph Boyes of Los Angeles.

Topics will include trauma of the hand, head, chest, abdomen, heart, knee, shoulder, treatment of burns, athletic injuries, and other subjects selected in answer to a questionnaire sent last year's registrants. Illustrated lectures, patient demonstrations, and question and answer periods will also be held. All inquiries may be addressed to Dr. John J. Fahey, 1791 W. Howard St., Chicago 26.

Report of Delegates To American Medical Association 1957 Clinical Meeting

Fluoridation of public water supplies, free choice of physician, the Heller Report on organization of the American Medical Association, the Forand Bill providing hospital and surgical benefits for Social Security beneficiaries, guides for occupational health programs covering hospital employees, distribution of Asian Influenza vaccine and guides for the medical rating of physical impairment were among the variety of subjects acted upon by the House of Delegates at the American Medical Association's Eleventh Clinical Meeting held Dec. 3-6, 1957 in Philadelphia.

Dr. Cecil W. Clark of Cameron, La., was

named 1957 General Practitioner of the Year after his selection by a special committee of the Board of Trustees for outstanding community service. Dr. Clark, 33 year old country doctor who was a medical hero during Hurricane Audrey last June, was present at the meeting to receive the gold medal which goes with the annual award.

Speaking at the opening session on Tuesday, Dr. David B. Allman of Atlantic City, A.M.A. President, called for "more freedom, not less, in America and in the medical profession." Dr. Allman urged the delegates to embark on local action campaigns to enlist full community support in opposition to the Forand Bill, a pending Congressional proposal which would provide hospital and surgical benefits for persons who are receiving or are eligible for Social Security retirement and survivorship payments. The Forand Bill, he said, is "cut from the same cloth" as national compulsory health insurance and "emanates from the same minds."

Total registration at the end of the third day of the meeting, with half a day still to go, had reached 5,375, including 2,562 physician members.

Fluoridation of Water

In settling the most controversial issue at the Philadelphia meeting, the House of Delegates approved a joint report of the Council on Drugs and the Council on Foods and Nutrition which endorsed the fluoridation of public water supplies as a safe and practical method of reducing the incidence of dental caries during childhood. The 27 page report on the study which was directed by the House at the Seattle Clinical Meeting one year ago contained these conclusions:

"1. Fluoridation of public water supplies so as to provide the approximate equivalent of 1 ppm of fluorine in drinking water has been established as a method for reducing dental caries in children up to 10 years of age. In localities with warm climates, or where for other reasons the ingestion of water or other sources of considerable fluorine content is high, a lower concentration of fluoride is advisable. On the basis of the available evidence, it appears that this method decreases the incidence of caries during childhood. The evidence from Colorado Springs indicates as well a reduction in the rate of dental caries up to at least 44 years of age.

"2. No evidence has been found since the 1951 statement by the Councils to prove that continuous ingestion of water containing the equivalent of approximately 1 ppm of fluorine for long periods by large segments of the population is harmful to the general health. Mottling of the tooth enamel (dental fluorosis) associated with this level of fluoridation is minimal. The importance of this mottling is outweighed by the caries-inhibiting effect of the fluoride.

"3. Fluoridation of public water supplies should be regarded as a prophylactic measure for reducing tooth decay at the community level and is applicable where the water supply contains less than the equivalent of 1 ppm of fluorine."

Free Choice of Physician

Acting on the issue of free choice in relation to contract practice, the House passed a resolution which reaffirmed approval of previous interpretations of the Principles of Medical Ethics by the Association's Judicial Council and directed that they be called to the attention of all constituent associations and component societies. One Council opinion, issued in 1927 and reaffirmed in Philadelphia, stated that the contract practice of medicine would be determined to be unethical if "a reasonable degree of free choice of physician is denied those cared for in a community where other competent physicians are readily available." The resolution also cited a Council opinion, published in the October 19, 1957, issue of The Journal of the A.M.A., which stated that the basic ethical concepts in both the 1955 and 1957 editions of the Principles of Medical Ethics are identical in spite of changes in format and wording. This opinion added that "no opinion or report of the Council interpreting these basic principles which were in effect at the time of the revision has been rescinded by the adoption of the 1957 principles."

The 1927 Council report also pointed out that "there are many conditions under which contract practice is not only legitimate and ethical, but in fact the only way in which competent medical service can be provided." Judgment of whether or not a contract is ethical, the report said, must be based on the form and terms of the contract as well as the circumstances under which it is made.

In another action related to the issue of free choice, the House adopted a resolution condemning the current attitude and method of operation of the United Mine Workers of America Welfare and Retirement Fund "as tending to lower the quality and availability of medical and hospital care to its beneficiaries." The resolution also called for a broad educational program to inform the general public, including the beneficiaries of

the Fund, concerning the benefits to be derived from preservation of the American right to freedom of choice of physicians and hospitals as well as observance of the "Guides to Relationships Between State and County Medical Societies and the UMWA Welfare and Retirement Fund" which were adopted by the House last June.

The Heller Report

Acting on the report of the Committee to Study the Heller Report on Organization of the American Medical Association, the House reached the following decisions on 10 specific recommendations:

1. The office of Vice-President will be continued as an elective office.

2. The offices of Secretary and Treasurer will be combined into one office to be known as Secretary-Treasurer, and that officer will be selected by the Board of Trustees from one of its number.

3. The duties of the Secretary-Treasurer will be separated from those of the Executive Vice-President.

4. The office of General Manager will be discontinued, and the new office of Executive Vice-President will be established. The latter, appointed by the Board of Trustees, will be the chief staff executive of the Association.

5. The Council on Medical Education and Hospitals and the Council on Medical Service will continue as standing committees of the House of Delegates, but their administrative direction will be vested in the Executive Vice-President.

6. The voting members of the Board of Trustees will be limited to 11 — the nine elected Trustees, the President and the President-Elect. The Vice-President and the Speaker and Vice-Speaker of the House of Delegates will attend all Board meetings, including executive sessions, with the right of discussion but without the right to vote.

7. The House disapproved of the proposal to elect the Trustees from each of nine physician-population regions.

8. The office of Assistant Secretary will be discontinued, and a new office of Assistant Executive Vice-President will be established.

9. The Committee on Federal Medical Services will be retained as a committee of the Council on Medical Service and will not become a part of the Council on National Defense.

10. The Speaker of the House will appoint a joint and continuing committee of six members, three from the Board of Trustees and three from the House, to redefine the central concept of A.M.A. objectives and basic programs, consider the placing of greater emphasis on scientific activities, take the lead in creating more cohesion among national medical societies and study socioeconomic problems.

The accepted recommendations were referred to the Council on Constitution and By-laws with a request to draft appropriate amendments for consideration by the House at the 1958 annual meeting in San Francisco.

The Forand Bill

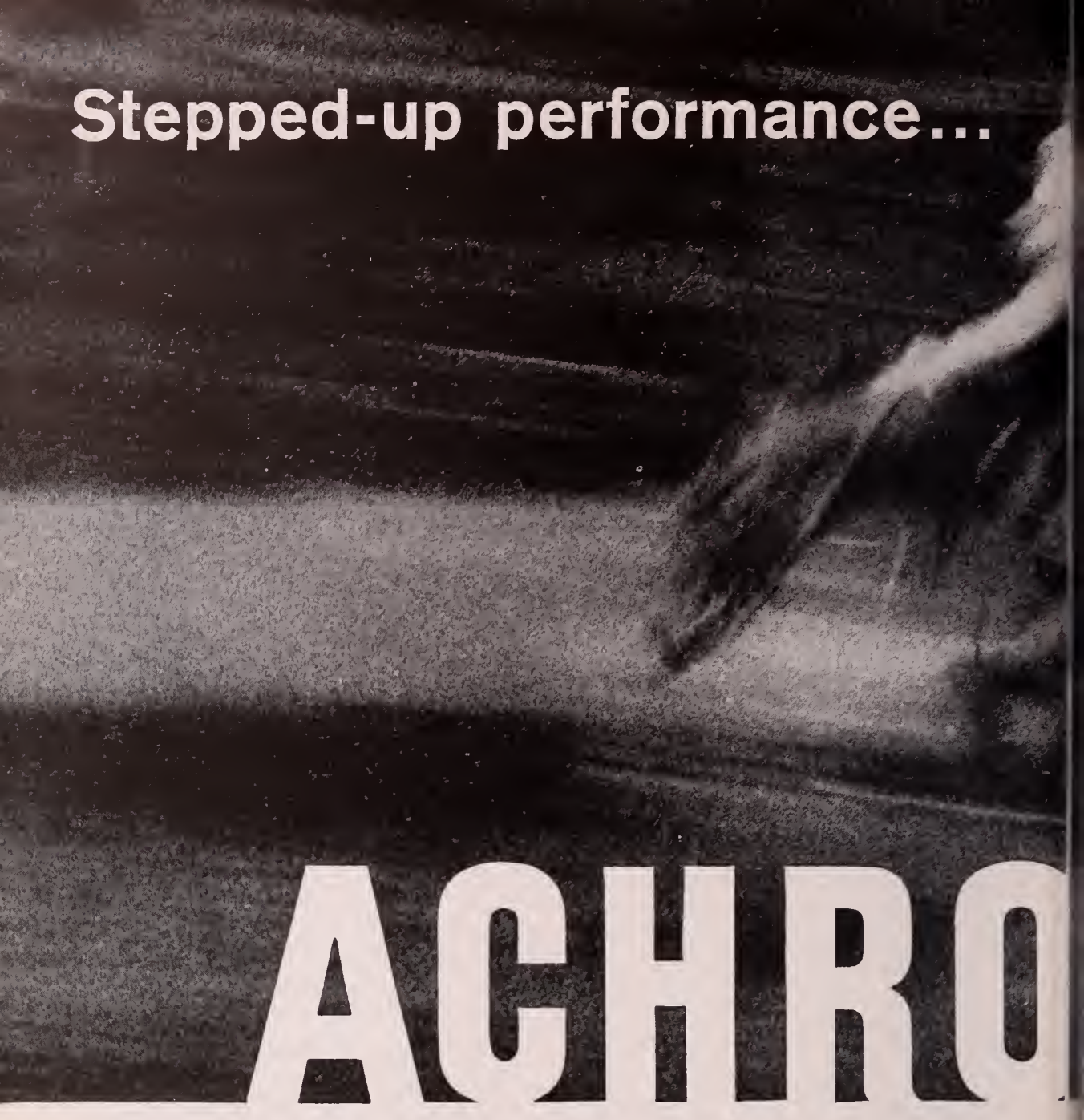
The House condemned the Forand Bill as undesirable legislation, approved the firm position taken in opposition to it and expressed satisfaction that the Board of Trustees has appointed a special task force which is taking action to defeat the bill. In a related action, giving strong approval to Dr. Allman's address at the opening session, the House adopted a statement which said:

"It is particularly timely that our President has so forcefully sounded the clarion call to the entire profession for emergency action. With complete unity, definition and singleness of purpose, closing of ranks with all age groups and elements of our organization we must at this time stand and be counted. Thus we can exert the physician's influence in every possible direction against invasion of our basic American liberties in the form of proposed legislation alleged to compulsorily insure one segment of the population against health hazards at the expense of all."

Health Programs for Hospital Employees

A set of "Guiding Principles for an Occupational Health Program in a Hospital Employee Group" was approved by the House. The guides were developed by a joint committee of the American Medical Association and the American Hospital Association and already had been formally approved by the A.H.A. They include these statements:

"Employees in hospitals are entitled to the same benefits in health maintenance and protection as are industrial employees. Therefore, programs of health services in hospitals should use the techniques of preventive medicine which have been found by experience in industry to approach constructively the health requirements of employees.



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"It is essential that employee health programs in hospitals, as in industry, be established as separate functions with independent facilities and personnel. The fact that hospitals are engaged in the care of the sick as their primary function does not alter the necessary organizational plan for an effective occupational health program."

Asian Influenza Vaccine

The House considered three resolutions dealing with the Asian influenza immunization program and then adopted a substitute resolution calling attention to "certain inadequacies and confusions in the distribution of vaccines" and directing the Board of Trustees to seek conferences through existing committees "with a view to establishing a code of practices regulating the future distribution of important therapeutic products, so that the best interest of all the people may be served." The resolution pointed out that the American Medical Association already has a joint committee with the American Pharmaceutical Association and the National Association of Retail Druggists, in addition to a liaison committee with the Drug Manufacturers Association.

Medical Rating of Physical Impairment

The House accepted a 115 page "Guide to the Evaluation of Permanent Impairment of the Extremities and Back" which was developed by the Committee on Medical Rating of Physical Impairment as the first in a projected series of guides. The delegates commended the committee for doing "a superb job on this difficult subject" and expressed pleasure that the guides will be published in The Journal of the A.M.A. The guides are expected to be of particular help to physicians in determining impairment under the new disability benefits program of the Social Security Act.

Miscellaneous Actions

Among a wide variety of other actions, the House also:

Directed that a new committee be established in the Council on Industrial Health to study neurological disorders in industry;

Noted with approval the establishment of the American Medical Research Foundation.

Decided that informational materials which are sent to A.M.A. delegates should also be sent to all alternate delegates;

Affirmed that it is within the limits of ethical propriety for physicians to join together as partnerships, associations or other lawful groups provided that the ownership and management of the affairs thereof remain in the hands of licensed physicians;

Instructed that the appropriate committee or council should engage in conferences with third parties to develop general principles and policies which may be applied to the relationship between third parties and members of the medical profession;

Urged state medical society committees on aging and insurance to make continuing studies of pre-retirement financing of health insurance for retired persons;

Endorsed a suggestion that the Committee on Federal Medical Services sponsor a national conference on veterans' medical care during 1958;

Asked the Board of Trustees to study the feasibility of having the Association finance a thorough investigation of the Social Security system by a qualified private agency;

Suggested that physicians and their friends make a vigorous effort to obtain Congressional enactment of the Jenkins-Keogh Bills;

Approved the "Suggested Guides to Relationships Between Medical Societies and Voluntary Health Agencies";

Strongly recommended that a completely adequate and competent medical department be established in the Civil Aeronautics Administration directly responsible to the CAA Administrator.

Opening Session

At the Tuesday opening session Rear Admiral B. W. Hogan, Surgeon General of the U. S. Navy, presented the Navy Meritorious Public Service Citation to Dr. Dwight H. Murray of Napa, Calif., immediate past president of the Association. Contributions to the American Medical Education Foundation, for financial aid to the nation's medical schools, were presented by four state medical societies: California, $143.043.25; Utah, $10.390; New Jersey, $10.000, and Arizona, $8,040. The Interstate Post Graduate Medical Association of North America gave $1,000, and the Illinois State Medical Society announced that it was adding $10,000 to the $170,450 presented at the New York meeting last June.

Respectfully submitted,

Louis M. Orr, M.D.
Reuben B. Chrisman Jr., M.D.
Francis T. Holland, M.D.

BLUE SHIELD

Informational Meeting Held for Blue Shield Active Members

On Dec. 7, 1957, an informational meeting of the Active Members of Blue Shield was held at the Blue Cross - Blue Shield Building in Jacksonville. Some 105 of the Active Members of Florida Blue Shield, which includes the seated House of Delegates of the Florida Medical Association, met in an all day session to hear presentations about Blue Shield and to participate in discussions concerning the past, present and future of the Florida Plan.

By resolution of the House of Delegates, it was the purpose of the meeting to inform the profession better on prepayment matters and to improve the channels of communication between the profession and the Plan. No authority to act was granted; therefore, no voting or final action was taken at the meeting.

The program, arranged by the Florida Medical Association Advisory Committee to Blue Shield and the Blue Shield Board of Directors, featured two speakers of national prominence in the field of medical economics, Dr. Fredrick H. Good of Colorado, and Mr. Jay C. Ketchum of Michigan, as well as speakers of prominence and authority from the state organization. Also included was a panel discussion in which the Committee of Seventeen presented various topics and the entire assembly joined in a general question and answer period.

Dr. William C. Roberts, President of the Florida Medical Association, in a brief talk stated that he was intensely interested in Florida Blue Shield and that he favored a complete study of it by Florida Physicians. He said that in his recent travels he had found organized medicine over the country watching Florida's decisions. He also indicated that he believed the Florida Plan now was a reasonable facsimile of what Blue Shield should be and urged that all doctors acquire better knowledge of prepayment and be prepared to make decisions regarding it at the next annual meeting of the Association.

Dr. Russell B. Carson, President of Florida Blue Shield, reviewed the history of Florida Blue Shield, its relationship to Blue Cross, and its responsibility to the profession, the public and the State Insurance Commissioner. Speaking of its relationship to Blue Cross, Dr. Carson pointed out that all the facilities, including the building, used by Blue Shield were the property of the Blue Cross Plan and that Blue Shield was a renter from that corporation. He also commented on the financial aspects of the Plan that have given the Board of Directors concern for the past few years. He indicated that the Plan was now paying 86.5 per cent of its income to the doctors for services rendered its subscribers.

Addresses by Dr. Henry J. Babers Jr., Chairman of the Florida Medical Association Advisory Committee to Blue Shield, and Judge Ben C. Willis, Judge in the Second Judicial Circuit Court and a member of the Board of Directors of Florida Blue Shield, are published in this issue of The Journal of the Florida Medical Association. The other addresses made at the meeting are scheduled for publication in subsequent issues of The Journal.

Many favorable comments at the time of the meeting and correspondence from individuals and societies since that time indicate that the meeting was successful in creating an area of better understanding between the physicians of Florida and their Blue Shield Plan. The Florida Medical Association Advisory Committee to Blue Shield and the Blue Shield Board of Directors invite your comments.

Opening and Explanatory Remarks

Henry J. Babers Jr., M.D.
GAINESVILLE
Chairman of the Florida Medical Association
Advisory Committee to Blue Shield

Gentlemen: It is time for us to start our meeting because there are many important things to be discussed here today. We should all feel at home in this building because it has been made possible by our control and support, especially the medical leaders who began Blue Shield of Florida in 1946.

It is fitting that we start this important meeting with a prayer, and I have asked Dr. Henry L. Harrell of Ocala to lead us in prayer.

(Prayer by Dr. Harrell)

In 1956 (it seems years ago now) at the annual meeting of the Florida Medical Association,

at the request of the Dade County Medical Association and also by request of the Board of Directors of Blue Shield of Florida, a resolution was presented and passed requesting a committee of the Florida Medical Association to act as Advisory to Blue Shield and as a reference committee for Blue Shield matters. This resolution was presented by Dr. Louis M. Orr (who was chairman of the reference committee) and seconded by Dr. H. Phillip Hampton. This group of doctors was appointed by President Langley in August 1956, and had its organizational meeting on Sept. 30, 1956.

Little did we know what we were getting into. Our thoughts were much the same as those of many of you in reference to Blue Shield. We simply knew nothing about the immensity of the economic problems facing the medical profession except in a general sort of way; we found that Blue Shield was only a small but important facet of the over-all problem. We can show you our committee minutes and show you that we all had our own ideas of what to do and what was wrong; but we were wise as a group (I admit that freely). We said that we would not make any statements until we knew what we were talking about. As individuals, we have not hesitated to state our feelings; but as a committee, we have been very careful. Please refer to our report, the Committee of Seventeen's Report, to the House of Delegates at the last annual meeting of the Association, published in The Journal of the Florida Medical Association and you will find that this is true.

We want you to know that from the outset we refused to make ourselves apologists for Blue Shield. We were and we have remained a Florida Medical Association committee to study Blue Shield problems and to advise Blue Shield through the Association. Blue Shield through its Board of Directors and administration, and this is important, has shown itself completely cooperative; we have been given every bit of information on its operation; nothing has been withheld.

At first, we decided mainly to study the situation about which we quickly recognized much ignorance on our part. Later, we voted to get and give information to and from the membership of the Association. Little did we know as a committee how doctors individually, in county societies and in specialty groups, would respond to our efforts.

Our group has studied. We have had four long meetings on Sept. 30, 1956, Dec. 2, 1956, April 7, 1957, and July 28, 1957. Most of our members have attended all of these meetings, and that in itself is remarkable because of the time, expense, and distances involved. I now honestly believe that a majority of our group have a great deal more knowledge of our economics than do the majority of doctors in Florida. We have been consistent. We agreed after study that we believed that Blue Shield was, by its nature, a good thing and should be continued. (Dr. Donald F. Marion was not a member of this committee until June 1957; so I will not include him in this statement, although I hope and believe he agrees with me.) If you will look into our actions, you will see that we have been fair and judicial in our approach. We want to be consistent and fair, and there is not a Casper Milquetoast in the lot of us.

So surely, it must be evident that there is some reason for our obvious worries. Every now and then a doctor will ask, "What in the world are you talking about? What controversy?" There is controversy, and if a man does not recognize it, that does not mean there is not. Is there any reason but common sense why so many of us can see this problem in a different light than many of you? Is there possibly any ulterior motive that would make any of us say or do anything that was not honest or fair? We have had our motives questioned. Our knowledge after a year of study has given us insight into problems that many of you do not realize exist. Do you have any knowledge of the responsibilities of Blue Shield's Board of Directors to the Insurance Commissioner of the State of Florida? Do you have any knowledge of the make up of the Board of Directors of Blue Shield? Do you know that its members, both physicians and laymen, are people of the highest caliber and integrity? Do you realize the importance of having such laymen on the side of medicine when the public tests come, and soon? If I have learned anything from this work, it is the power and help we get from the laymen.

Do you realize that with our vacillation, incompetence and bickering on economic problems we run the risk throughout the country of such friends of medicine becoming disgusted with us? We could not blame them if they did, but fortunately they are men and women of stature who see beneath our inconsistencies and like us for our good qualities. Do you think that the members of the Board of Directors of Blue Shield benefit monetarily from Blue Shield? The facts are clear; they do not. At times I wonder why

they continue. Suffice it to say that within them (and all of us, I hope) there is still the American current of fair play and the feeling of public service; otherwise, I am sure our leaders both medical and lay would throw up their hands and go home or else hang themselves from the handiest limb.

Now a word of explanation of how this educational meeting came about. At the last annual convention of the Association in 1957 a resolution was passed on the sponsorship of the Committee of Seventeen requesting Blue Shield to have an informational meeting. This was agreed to by the voting members of Blue Shield and by the Board of Directors, hence this gathering today. And believe me, we have every reason to say a prayer for guidance.

This meeting is important, and it is gratifying to see so many here this early. I think that it is a bit unusual in a medical group, and Florida is a long state. With the cooperation of Blue Shield, we have prepared a full program. We have brought here two national figures, Dr. Fredrick H. Good of Colorado and Mr. Jay C. Ketchum of Michigan, whom we will introduce in due time.

As our work program has developed, one thing has become obvious to us: Things are not simple. When you make one move, you do not always realize that it may cause two or three other things to happen that you did not consider when you made the original move; so things are not simple. There are a thousand angles to the economics in medicine. A striking and dismaying factor at times has been for us to find tremendous diversity and lack of unity of our general membership in Florida.

Here, then, is the beginning of our meeting and here is our projected course of action. If one wishes to make a good decision on any matter, he must know what he is doing. Do not buy a pig in a poke or some phony uranium stock, but do not turn down a good proposition either. We have learned to our utter amazement, at times, that doctors can go from sheer apathy to rank hysteria in one jump on these economic problems; they will at times insult their friends and bless their enemies without knowing what they are doing. We have realized that if we applied the same methods to medical care problems as we do to the economics of medicine, no patient would be safe. Thank heaven, by training and aptitude, doctors do use reason and analysis in medical cases, but often they do not in economics. Here is the projected course of action: At this meeting we hope to give you many of the facts and ideas concerning Blue Shield that we have learned in the past year. At least, if we have to put on the gloves and fight, let us know what we are fighting about; let us truly understand the issues. This we hope to do today, to outline the facts. There is nothing to decide today. Let your heads and consciences guide you to your future course.

After today, our Committee will continue to study and to make available to you all information possible including the thoughts of our "Grass Roots" in the membership. Then by the time of the next annual meeting of the Florida Medical Association, in the spring of 1958, let us make a decision. Too, let us hope that all elements of the Florida Medical Association will combine to make whatever this decision is, in reference to Blue Shield, unanimous, or at least in great majority. Our Committee has requested of the Board of Governors, and they have agreed, that adequate time and space be alloted in reference committee for a full formal debate and then decision of the House of Delegates on three matters: (1), whether to continue Blue Shield with good and positive support, or not to continue Blue Shield after that; (2) to straighten out the inequities of Blue Shield, especially in reference to the nonsurgical portions, if we wish to continue Blue Shield; and (3) to empower somehow, someway, Blue Shield so that it can act and not be completely hamstrung as it is now, if we vote to continue Blue Shield.

So today's program is simply setting the stage for the spring meeting, and you are hereby put on notice. Please let everybody at home know. In reference committee at that time, an agenda should be set up so that all interested parties can be heard; this should be worked out ahead of time so that each person heard has thought out his remarks carefully and the hearing does not degenerate into a foolish time-wasting hassel, out of keeping with our medical heritage. Could anything be fairer?

Please refer to the agenda for this meeting. The first half until after lunch is for Blue Shield to present its position as an insurance vector, responsible to the laws of the State of Florida and to the public as well as to the medical profession. The afternoon will be devoted to the presentation by the Committee of Seventeen, including a panel discussion.

Blue Shield From The Layman's Viewpoint

JUDGE BEN C. WILLIS
TALLAHASSEE

Circuit Judge, Second Judicial Circuit and
Member of the Board of Directors of Florida Blue Shield

Dr. Carson, Dr. Babers and Active Members of Blue Shield, I am deeply grateful to Dr. Carson for his more than generous remarks and I am sure that he has committed a gross extravagance in the estimate that he has given of my services or my contribution to the Blue Shield Board of Directors.

I have been requested to talk a few minutes about a layman's observation, or "Blue Shield from the Layman's Viewpoint." When I speak of layman, I mean one who is not a Medical Doctor.

My first contact with Blue Shield, or my first real knowledge that there was such an organization, came through a physician. I had been like everyone else, I suppose, plagued almost daily by insurance agents of one kind or another, who wanted me to increase my life insurance, or take out insurance on my home to provide against this calamity and that holocaust, and one thing and another, until there had been built up a great deal of resistance. I remember, however, one social evening when, quite casually, a physician in my home town described to me something of Blue Cross and Blue Shield, and for the first time, I learned that Blue Shield was an organization that was created by and administered by physicians. Immediately, I became interested, and when an opportunity came some months later, when individual applications were being received in my county, I eagerly submitted an application and became a subscriber. I mention my experience for the reason that I think it was not greatly different from that of many others. The reason that Blue Shield and Blue Cross, its twin and the organization which goes hand in hand with Blue Shield, have achieved such remarkable success, not only in Florida, but the Plans in other states, has been the fact that the medical profession was associated with it.

Observing as a layman, the members of the medical profession and the medical profession as a whole, I find, and I think the overwhelming majority of the public finds that it is a group of men and women who are highly trained, who are highly skilled and who are accomplished scientists and artists. In addition to their proficiency and their skills, they also are a dedicated group of people. They are dedicated professionally and dedicated to the highest of human attributes, the relief of suffering, and the curing of ills of the human race. This combination of attributes necessarily associated with their profession, the skill, the training and the dedication that go with it, has placed the physician—and I do not think that many of you realize it—in high regard among his fellow men.

I know that the physician perhaps thinks more of the ungrateful patient who has complained of what he thought was a modest bill after he had rescued that patient from the brink of death. Or, perhaps he thinks of the uncharitable remarks that some uninformed person would make about the nature of certain treatment that had been given, but I venture to say, gentlemen, that for every complaint you have had, for every unpleasant remark that has been made to you or about you, there are dozens who may not have expressed themselves, but who regard you with deepest affection. Because they have observed that in practically every instance, and I think that is a universal truth, physicians are compassionate, and physicians are those who give encouragement and relief in times of great stress, you do have and you have earned a deep love and affection from the people among whom you dwell. That, gentlemen, is the reason Blue Cross and Blue Shield, particularly Blue Shield, have the appeal they do to the public; it is because the physicians are associated with it, and because the public associates with the physician the very highest of integrity, the very highest in service and the very best of everything. That was the reason I became interested in Blue Shield and became a subscriber.

Since that time, I have had some opportunities to know a little bit more about Blue Shield. I had the privilege of being the legislative consultant, sometimes vulgarly referred to as a lobbyist, in the state legislature for a number of interests including Blue Shield, and I had to learn, and did learn, much of the inner workings of the organization. At first, my impression was that it was just another insurance company, that perhaps a group of doctors had put up the money, and that they owned and controlled and administered the company. I find that I was in error. It was originated by the physicians, and it was through the devoted efforts, and sometimes the very discouraging efforts, of some energetic and

ambitious people that Blue Shield of Florida came into existence. There was at one time enough money put up to get it started, but there is not a dime now that is owned by anyone.

Blue Shield is an insurance company to be sure. It is a corporation; but unlike the ordinary corporation, it has no stockholders, it has no dividends, but it does have a tremendous service. The ones who foot the bill, the subscribers, have no voice whatever in its operation. They have no voice in the choice of directors; they have no vote in any of its deliberations. The subscribers are contributing and are placing into the channels of Blue Shield something like a half million dollars each month; and as Dr. Carson has stated, 86.5 per cent of this amount is returned to the subscriber, that is, nominally it is returned to the subscriber, but actually it goes into the pockets of the physicians of Florida because the benefits are paid directly to the physicians. So it is a multimillion dollar proposition so far as the physicians of this state are concerned.

Very properly, the enabling act requires that a majority of the Board of Directors shall be physicians. Actually, 12 out of 19 members of the Board of Directors are physicians. Now, what would be comparable to the stockholders, that is, those who have a voice in the election of directors and the direction of the policy, is also cast very heavily in the medical profession. It is provided that the Active Members of Blue Shield, of which this is an assembly, shall be the members of the House of Delegates of the Florida Medical Association, plus the Blue Shield Board of Directors, and there is some word about such other persons as may be elected to membership. There is also the requirement that such other persons shall never exceed 20 per cent of the entire membership. So you can see that from the very requirements of the organization, it is the medical profession which dominates it, as it should do. So it is your Blue Shield. It is the Blue Shield of the Florida physicians.

I have also had the privilege of observing the operation of the Florida Medical Association, which I think is one of the finest organizations in the state. It is certainly a very representative organization. I believe that you have a large percentage of the practicing physicians as members of your Florida Medical Association. It is the delegates from the individual societies, presumably I suppose, chosen by the physicians themselves in their local societies, who constitute the active members of this organization.

Being a multimillion dollar organization and being an insurance company, subject to regulation by the State Insurance Commissioner, having an obligation to its subscribers, steadily growing as it has in the past and bids to do in the future, Blue Shield is confronted with created problems. There are created problems of policy. There are created problems of trying to anticipate developments and to meet conditions which are rapidly changing. Perhaps the initial reason for the bringing into existence of Blue Cross and Blue Shield was the fact that the commercial insurance companies themselves were reluctant to enter the prepaid medical and hospital care program. It is understandable because commercial companies have to show a profit. It requires a tremendous outlay both in money and in organization to put a program like this over, and the chances are, without experience behind them, the companies were reluctant to go into this field because they did not know just what the result might be.

After it was pioneered by the Blue Shield and Blue Cross corporations, however, and it was found that it would work and did work, the commercial companies came into the field. Their activity presents a problem, too, to Blue Shield, in that it does have competition. It is competition that is actively seeking, though not dishonorably —I am not going to accuse any insurance company of being dishonorable—to eliminate Blue Shield. They would like to see Blue Shield fail. They would like to see it out of the picture because it is a good thing and something in which they would like to be more active and have a bigger share. Blue Shield has never sought to be exclusive in this field. It has welcomed competition, it has welcomed the opportunity that the public would have to receive whatever benefits the commercial companies are able to provide. We, however, are here and we must recognize that we do have competition. If we are to survive, and to carry on the program which has been set out, that competition must be recognized and that competition must be met.

I paid you a compliment, that is, I paid the medical profession a compliment a moment ago. It was not a compliment that is undeserved by any means or in any way exaggerated, because you do have the affection, the regard, and the confidence of your fellow men. I do want to point out, however, that there is nothing that reminds me so

much of a group of lawyers, as a group of doctors. When we get together and have our meetings, we behave just about like a group of doctors, and I imagine the engineers and the other professions behave pretty much the same way. I do want to mention this in all good humor and in all sincerity, and without any intention of being critical because it is perfectly natural that when persons do become highly skilled and become artists, there are a few who become prima donnas. I am happy to say, that from my observation, those have been in the great minority and that the great majority have sought to approach whatever questions or problems that may have confronted them, or may have occurred to them, on a very rational and reasonable basis with a keen desire to pursue them as one would any other scientific fact, to search for and obtain the truth.

Blue Shield is not beyond criticism. It is not beyond improvement. There are many instances in which criticism is warranted and welcomed and from which improvements have been made. Nevertheless, for all of those criticisms that come about in a reasonable and rational manner, when they are presented in other ways, it creates a great handicap to those who are attempting to form the policy or to administer the actual workings, because it takes time and sometimes it takes a great deal of time to fathom what is behind many of these things and to get to the bottom of it. I believe that the Committee of Seventeen has done a wonderful job in bringing to the physicians of this state the problems of Blue Shield and also in bringing to the Board of Directors and to the management of Blue Shield the problems of the physicians, so that the two might be matched and the problems might be resolved. I think a great deal of misunderstanding has been dissipated. More in that line of course is needed and will always be needed; it is a continuing project.

I should like to impress upon this group that Blue Shield is yours. It is yours to continue to grow and continue to serve, or it is yours to destroy. It will do one or the other. It will not stand still. Blue Shield must meet changing conditions, it must meet competition, it must seek to give the service that the public itself is demanding, and which it will get one way or another, either from the government or from the commercial insurance companies, if they are willing to enter it. The public is going to get what it demands, one way or the other. There are many fine things about a Blue Shield Plan. I think it preserves the very finest that we have in our system of economics. It certainly recognizes the value and the necessity of free enterprise. It recognizes the sanctity of the physician and patient relation. It recognizes the freedom of choice of the patient or the physician. It recognizes all that we cherish and hold dear and it seeks and has accomplished much towards solving the great problem which has faced our people in these times of having an income which barely provides what we consider to be the actual necessities.

Very few of us, and I say "us," set aside very much for the so-called rainy day. We are not able to do so even though our income may be considered rather substantial. We feel that we want to educate our children and want to send them to creditable colleges and universities. We feel that we want to maintain certain standards in our home. We want to have a comfortable home and we want it equipped. We do not want a fireplace; we want a furnace. We do not want an old gramophone; we want a TV set. We want the things that we feel our age and times entitle us to have. When those things are provided, we find that there is not much to set aside for the rainy day. So a person can have a rather substantial income, and yet in a very short time become medically indigent. If suddenly some disease or accident befalls him and he is unable to continue his earnings and is required to make the expenditures which hospitalization and medical expenses bring forth now, he finds that in a short time he is behind the eight ball, so to speak. So, Blue Shield is not merely for the common laborer; it is not merely for the low-salaried worker; it really reaches into the realm of those who do have substantial incomes; and it does provide against those contingencies which arrive and relieves both the tensions and the economic demands that those unfortunate occurrences bring about.

I would ask that each of you take this message back to your fellows in your own communities; that if there is a problem, if there is a question, to try to understand the reason for the existence of the problem and come forth with a concrete suggestion for correcting whatever may be the thing to be criticized.

I think the management and Board of Directors both recognize that without the support that has been given by the physicians of Florida, Blue Shield would long ago have failed. There have, however, been instances in which they have been rather vexing. Criticisms have been resolved when

full knowledge was brought forth. I ask you to cooperate with your Committee of Seventeen, and to seek to know more about your organization and what it seeks to do and the problems that it faces.

I will tell this little story, in closing, of an old gentleman who had for many years nursed very tenderly and very devotedly an invalid wife who had suffered from rheumatism for about 30 years. When the dear old soul passed away, the old man was very much grieved and hurt. About six weeks later it was noticed that he began to pay attention to a rather young woman; and finally, to the surprise of the community, the announcement was made that he and this young girl had married. One of his old friends went to him and said, "Well, Uncle John, it's mighty fine, glad you did it, hope you'll be happy, but you were so devoted to your first wife that it comes as sort of a surprise to us that you have done this thing." He replied, "Well, son, I smelled liniment for 20 years and now I'd like to smell a little perfume." So, the Board of Directors and the management would like to smell a little perfume. Thank you.

OTHERS ARE SAYING

Doctors Are Dedicated

"Doctors should be dedicated," is heard frequently enough when laymen discuss physicians. That type of conversation is usually triggered by an occasion when no physician can be found at the precise moment that the patient expects him to be on tap. The inference is that their ideal is a chap who is always on hand, day or night, 7 days a week, 52 weeks a year; and that the physician who is not Johnnie-on-the-spot is not dedicated. This "devoted" fellow never sleeps, never takes a vacation, never sends a bill, never deviates from his jolly, unruffled composure, and always goes along with every suggestion that the family makes. To complete the deal he has to die prematurely of a heart attack or double pneumonia incurred in the course of some extraordinary exhibition of medical heroism, such as getting out of his sick bed at 2 a.m. and plodding his way 2 miles through 2 feet of snow to get to some kid whose mother just found out he had swallowed a nickel two days ago.

Well then, what is a dedicated physician? It doesn't have to be a person who dashes into a burning building to save an unconscious child. Those other than physicians would do this if the calculated risks were favorable. He might be the physician who innocently enters a dive to sew up a cut, only to find carving knives brandished menacingly. He might be the physician who accidentally stabs himself with an i.v. needle dripping with luetic blood. He might be the physician who tries to make time on the icy glare of a highway strewn with wrecks, himself skidding through oncoming traffic and into the guard rail a half dozen times and ending up tipped over on his side. He might be the physician who sucks out a mouthful of inhaled vomitus with a rectal tube and goes back for more until breathing is restored. He might be the physician who goes into the den of a homicidal maniac to make an examination. He might be the isolated G.P. who operates on a red hot appendix because no surgeon would be available for many hours. He might be the physician who orders an appendectomy on an acutely ill patient who insists his appendix was removed when the hernia was repaired.

We know all of these "might have" situations have happened, and without considering them at the time to be any more than routine. It is likely that few physicians ever look upon themselves as being dedicated or not dedicated.

We feel that it is not the dramatic incidents taking a total of a few hours of a physician's lifetime that count. A physician is more likely than not to be dedicated if he is a consistent worker. (Anything over 40 hours a week should do, and allow him at least 2 weeks vacation a year.) He is dedicated if he inconveniences himself day or night for anyone who feels worse than he does. He is dedicated if he takes enough time off, and at proper intervals, to keep his body fit and his mind keen. He is dedicated if he forgets to send any other than the first bill in certain hardship cases, but is businessman enough to provide for his family and his family's future, with due regard to the investment made in money and arduous years of application. He is dedicated if he has the right proportion of empathy and sympathy to make a neat job of children's injuries and still have them like him. He is dedicated if he pulls his weight at staff meetings, medical society meetings, medical conventions and in committee work. He is dedicated if he goes to church, takes an interest in civic affairs, gets acquainted with his

family occasionally, and has a few friends in to dinner.

We believe that physicians, almost without exception, are dedicated. They should in their daily contacts play down the intriguing and amusing incidents of practice. They should accent the devotion of daily duty and the varied social and quasi-medical activities that make the whole man. Through the medical press and other media of publicity there should be a continuing education of the patient to get him down to earth.

To some a dedicated physician is one who is so hypnotized by the emotional impact of his profession, the glamour, the appeal of the distressed, the noble and spiritual concepts of the healing art that the practical side never touches him. They see him up there surrounded by a glow of light, suspended ecstatically between his halo and his pedestal, ignoring the laws of gravity. It has been said that a crack-pot is a person with 90 per cent zeal and 10 per cent motive. We'll take *dedicated* in lower case letters.

Massachusetts Physician
December, 1957

LETTER TO THE EDITOR

Dear Sir:

Recent reports in the ophthalmologic literature of toxic chorioretinopathy following the use of phenothiazine compounds as tranquilizing drugs lead me to believe it may be worth while to bring them to the attention of the medical population as a whole who prescribe most of these drugs.

Grant[1] in a review of ophthalmic pharmacology and toxicology quoted four reports of retinal pigmentary degeneration following the use of piperidylphenothiazine.[2-5]

Goar[6] reported severe toxic chorioretinopathy in 28 of 34 patients given chlorophenothiazine, some of whom apparently suffered permanent visual damage.

Sincerely
William J. Gibson, M.D.

1. Grant, W. M.: Ophthalmic Pharmacology and Toxicology, A.M.A. Arch Ophth. 58:265-281 (Aug.) 1957.
2. Kinross-Wright V.: Clinical Trial of New Phenothiazine Compound; NP-207, Psychiat. Res. Rep. 4:89-94 (April) 1956.
3. Rintelen, F.; Hotz, G., and Wagner, P.: N.P. 207, Med. et Hyg., Geneva, 14:426, 1956.
4. Verrey, F.: Dégénérescence pigmentaire de la rétine d'origine médicamenteuse. Ophthalmologica 131:296-303 (Apr.-May) 1956.
5. Wagner, P.: Investigation of Effect of Phenothiazine Derivatives on Fundus of Animals, Klin. Monatsbl. Augenh. 129:772-781, 1956.
6. Goar, E. L., and Fletcher, M. C.: Toxic Chorioretinopathy Following Use of N.P. 207, Am. J. Ophth. 44:603-608 (Nov.) 1957.

STATE NEWS ITEMS

Dr. Hawley H. Seiler of Tampa has been elected secretary-treasurer of the Southern Thoracic Surgical Association.

Dr. L. Roland Young of Daytona Beach after attending the Clinical Session of the American Medical Association in Philadelphia remained there a few days to visit clinics at the University of Pennyslvania Graduate School of Medicine.

The Fifty-Fourth Annual Congress on Medical Education and Licensure is being held Feb. 8-11, 1958, in the Palmer House, Chicago. It is sponsored by the Council on Medical Education and Hospitals of the American Medical Association; Advisory Board for Medical Specialties, and the Federation of State Medical Boards of the United States.

A grant of $64,000 has been awarded the University of Florida College of Medicine by the National Institutes of Health as a fellowship for Dr. Vergil H. Ferm, Associate Professor in Anatomy. The grant is to extend over a five year period during which time Dr. Ferm will continue his research in the role of placental function as it relates to the effects of various prenatal stimuli on the production of congenital malformations.

Dr. Hugh A. Carithers of Jacksonville has accepted the appointment as a member of the selection committee for the Wyeth Laboratories pediatric residency fellowship program. Recipients of the 20 two year pediatric residency fellowships to be offered annually by Wyeth, beginning July 1, 1958, are to be designated by the committee.

The 26th Annual Alumni Postgraduate Medical Convention of the College of Medical Evangelists begins Tuesday, February 25, at the Hotel Biltmore in Los Angeles. Ten nationally recognized physicians from medical centers across the country, an equal number of California physicians and three attorneys will participate in the three days of scientific sessions.

The Marion County Medical Society, through Dr. Richard C. Cumming of Ocala, has presented the Dr. Stewart Thompson Memorial Award to Mr. Raymond J. Sever of Hialeah, a student at



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G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

1. Axelrod, A. E.; Beaton, J. R.; Cannon, P. R., and others: Symposium on Protein Metabolism, New York, The National Vitamin Foundation, Incorporated, (March) 1954, p. 100.

2. Proceedings of a Conference on the Clinical Use of Anabolic Agents, Chicago, Illinois, G. D. Searle & Co., April 9, 1956, pp. 32-35.

SEARLE

the University of Miami School of Medicine at Miami. The award was given for outstanding scholarship and is one of two awards given as a memorial to Dr. Thompson. The other award has been presented to Mr. Santford Russell Wilson, a student at the University of Florida College of Medicine, Gainesville.

The New York University-Bellevue Medical Center's Post-Graduate Medical School is offering postgraduate courses in Medicine, Dermatology and Syphilology, Orthopedic Surgery, Opthalmology, Radiology, Pediatrics and Otorhinolaryngology to be given or started during the month of February. Information about the courses may be obtained from the Associate Dean, NYU Post-Graduate Medical School, 550 First Ave., New York 16.

Dr. Walter W. Sackett Jr. of Miami has been presented the second annual Outstanding Alumni Award given by the University of Miami Student Body Government. Dr. Sackett has been active in the American Academy of General Practice.

Grants totaling $12,000 have been awarded the University of Miami School of Medicine by the National Institutes of Health to be used to develop research programs in heart surgery and the relationship of different gases to the chemical energy of the heart. Physicians connected with the new research projects include Drs. Banning G. Lary, John J. Farrell, George Paff, Robert J. Boucek and Robert S. Litwak.

The Midwinter Meeting of the Florida Obstetric and Gynecologic Society was held late in November at the Ft. Harrison Hotel in Clearwater. Physicians presenting papers included Drs. Jackson L. Allgood Jr., Jacksonville; William T. Mixson Jr., Coral Gables; Henry L. Wright Jr., Tampa, and Arthur N. Berry, Columbus, Ga. A panel discussion was conducted by Dr. Ralph Gause, New York, and members of the panel were Dr. Robert Barter, Washington D. C., Dr. Berry, and Dr. Dorothy D. Brame, Orlando. Drs. Charles A. Johnson Jr. and Davis H. Vaughan, both of Clearwater, were in charge of local arrangements.

Dr. Duncan T. McEwan of Orlando, a past president of the Florida Medical Association, has been visiting clinics and hospitals in the Hawaiian Islands and in Japan.

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G. B. Griffith, President

Dr. Cayetano Panettiere of Miami Beach has been presented the Barry College Laudare Medal in recognition of outstanding service to the college and to the community.

Dr. William H. Everts of West Palm Beach has been elected president of the Florida Psychiatrists Association. Dr. Samuel G. Hibbs of Tampa will serve with Dr. Everts as secretary-treasurer.

Dr. Thomas H. Bates of Lake City has been reappointed a medical advisor by the American Cancer Society and has accepted appointment to the Society's Survey Committee and the Patient Aid Committee.

Dr. Caroline B. Hunter of Coral Gables has been elected president of the Women Physicians of the Southern Medical Association.

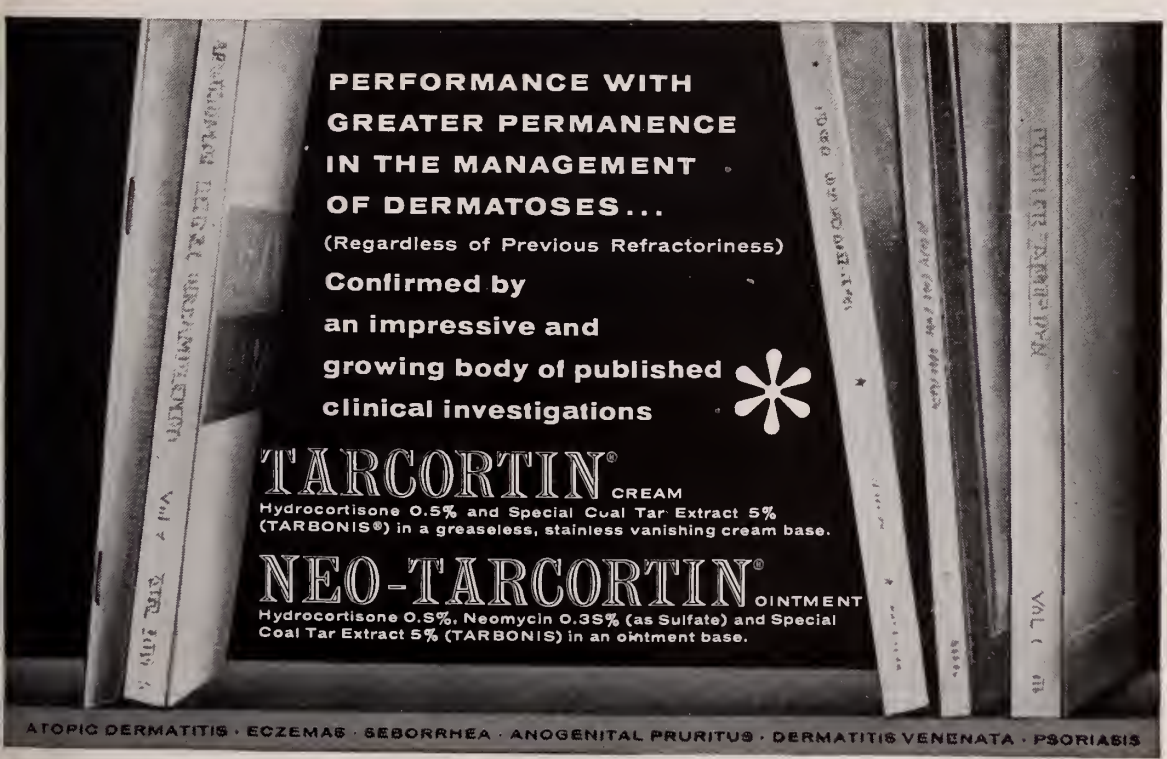
The Greater Miami Eye, Ear, Nose and Throat Society have elected the following officers for 1958: Dr. William B. Steinman, Miami, president; Dr. James H. Mendel Jr., South Miami, president-elect, and Dr. H. Carlton Howard, Miami, secretary-treasurer. The Society meets quarterly at the Urmey Hotel in Miami.

The Fifth International Congress of Internal Medicine will be held in Philadelphia April 23-26, 1958. This is the first meeting of the Society to be held in the United States and was arranged after an invitation was officially extended by the American College of Physicians.

Members of the Florida Medical Association attending the 1957 Clinical Meeting of the American Medical Association in Philadelphia included Drs. Louis M. Orr, Orlando; Reuben B. Chrisman Jr., Coral Gables; Francis T. Holland and J. Elizabeth Jeffress, Tallahassee; Homer L. Pearson Jr. and Carl H. Davis, Miami; Joseph J. Lowenthal, Bernard J. McCloskey and John H. Mitchell, Jacksonville; William C. Roberts, Panama City; L. Roland Young, Daytona Beach, and Richard A. Mills, Fort Lauderdale.

The Council on Postgraduate Medical Education of the American College of Chest Physicians will sponsor the Fourth Southern Postgraduate

(Continued on page 879)



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2. Bleiberg, J.: J. M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P. and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Welsh, A. L., and Ede, M.: Ohio State M. J. *50*:837, 1954.
5. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.

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Hospital practice of infant feeding

Standard formulas for NEWBORNS

Breast feeding is the procedure of choice fo the newborn. But it may need to be comple mented with standard formulas given here.

The first feeding, 12 hours after birth, consis of a prelacteal solution of 5% Karo Syrup, or or two ounces, repeated at two-hour interval Breast feeding is started on the second day fo five-minute intervals and the prelacteal feed ing continued immediately thereafter an between nursings.

Formula feeding is given on the second day breast feeding is denied. The small infa prefers the three-hour schedule and the lar infant the four-hour schedule.

The initial formula is a low-caloric milk mi ture, gradually increased in concentratio over several day intervals according to tole ance. Standard formulas for whole cow's mi or evaporated milk modified with dilute Karo Syrup as shown here, constitute th dietary regimen for well newborns.

First formulas for newborns, concentrated according to tolerance

Evaporated Milk Formulas: 3 oz. q 4h x 6 feedings

	FORMULA I 12.5 cals./oz.	FORMULA II 16 cals./oz.	FORMULA I 20 cals./oz.
Evap. Milk . .	4 oz	5 oz.	6 oz.
Water	14 oz.	13 oz.	12 oz.
Karo Syrup . .	1/2 oz.	3/4 oz.	1 oz.

Whole Cow's Milk Formulas: 3 1/2 oz. q 4h x 6 feeding

	FORMULA I 11 cals./oz.	FORMULA II 11.5 cals./oz.	FORMULA I 13.5 cals./oz
Whole Milk . .	8 oz.	9 oz.	10 oz.
Water	12 oz.	11 oz.	10 oz.
Karo Syrup . .	1/2 oz.	3/4 oz.	1 oz.

ADVANTAGES OF KARO IN INFANT FEEDING



Composition: Karo is a s perior maltose-dextrin mixtu because the dextrins are non-f mentable and the maltose rapidly transformed into dextr which requires no digestion.

Concentration: Volume f volume Karo furnishes twice many calories as similar mi modifiers in powdered form.

Purity: Karo is processed sterilizing temperatures, seal for complete hygienic protecti and devoid of pathogenic ganisms.

Low Cost: Karo costs 1/5th much as expensive milk modifi and is available at all food stor

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For the past two years, in a continuing search for more effective agents for enhancing oral antibiotic blood levels, our Research Laboratories screened eighty-four adjuvants, including sorbitol, citric acid, sodium hexametaphosphate, and other organic acids and chelating agents as well as phosphate complex and other analogs. After months of intensive comparative testing, glucosamine proved to be the absorption-enhancing agent of choice. Here's why:

1 Crossover tests show that average blood levels achieved with glucosamine were markedly higher than those of other enhancing agents screened. In some cases this effect was more than double.

2 Of great importance to the practicing physician is the consistency of the blood level enhancement achieved with glucosamine. Extensive tests show that the enhancing effect with glucosamine occurs in a greater percentage of cases than with any other agent screened.

3 Glucosamine is a nontoxic physiologic metabolite occurring naturally and widely in human secretions, tissues and organs. It is nonirritating to the stomach, does not increase gastric secretion, is sodium free and releases only four calories of energy per gram. Also, there is evidence that glucosamine may favorably influence the bacterial flora of the intestinal tract.

For these reasons glucosamine provides you with an important new adjuvant for better enhancement of antibiotic blood levels. Tetracycline, potentiated physiologically with glucosamine, is now available to you as COSA-TETRACYN.

Capsules 250 mg. and 125 mg.

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why wine in Cardiology?

FOR generations without number wine has been extolled as an "effective stimulant" and, therefore, valuable aid to treatment in various types of cardiovascular disease. It was this peculiar property, no doubt, which prompted the poet, Salerno, some 800 years ago to write—"Sound wine revives in age the heart of youth."

Now, as a result of modern research, we are obtaining concrete evidence of the favorable physiologic action of wine to lend support to the empiricism of ancient usage.

Both brandy and wine in moderate quantities have been found to substantially increase the pulse rate and step up the stroke volume of the heart.

Wine has been found to aid drug therapy in relieving the pain of angina pectoris and obliterative vascular disease.

Moreover, aside from the purely hypotensive actions of wine, its unquestionable euphoric effects help counter the depression, apprehension and anxiety so frequently present in sufferers from heart and coronary disorders.

The beneficial actions of wine appear to transcend those of more concentrated alcoholic beverages—valuable cardiotonic properties having been attributed to the aliphatic aldehydes and other nonalcoholic compounds recently isolated from certain wines and grape varieties.

It goes without saying that the use of alcohol, even in the form of wine, is contraindicated in hypertension accompanied by certain types of renal disease.



For a discussion of the many modern Rx uses for wine, write for the brochure, *"Uses of Wine in Medical Practice"* to Wine Advisory Board, 717 Market Street, San Francisco 3, California.

when are tranquilizers indicated in pediatrics ?

Some doctors have questioned the use of tranquilizers in children. They feel, and rightly so, that these drugs should not be used as palliatives to mask distressing symptoms, while etiological factors go uncorrected. But there are three situations in which even the most conservative physician would not hesitate to use tranquilizers:

1. When the usually well-adjusted child needs a buffer against temporary emotional stress, such as hospitalization.
2. When a child needs relief from an anxiety-reaction that is in turn anxiety-provoking, so as to pave the way for basic therapy.
3. When anxiety underlies or complicates somatic disease, as in asthma.

In such situations, tranquilizers are likely to be more effective and better tolerated than previously accepted therapy, such as barbiturates.

But the question arises: **which** tranquilizer is suitable for children?

Most of the physicians now using tranquilizers in pediatric practice have found the answer to be ATARAX, confirming the conclusions of repeated clinical studies.

ATARAX is effective in a wide range of pediatric indications.
ATARAX has produced a "striking response" in a wide range of hyperemotive states.* In a study of 126 children, "the calming effect of hydroxyzine (ATARAX) was remarkable" in 90%.* Among the conditions that are improved with ATARAX are tics, nervous vomiting, stuttering, temper tantrums, disciplinary problems, crying spasms, nightmares, incontinence, hyperkinesia, etc.*

ATARAX is well tolerated even by children.
"ATARAX appears to be the safest of the mild tranquilizers. Troublesome side effects have not been reported. . . ."*

ATARAX offers two pediatric dosage forms.
ATARAX Syrup is especially designed for acceptability by medicine-shy youngsters. A small 10 mg. tablet is also available. In either case, you will get a rapid, uncomplicated response. Why not, for the next four weeks, prescribe ATARAX for **your** hyperemotive pediatric patients. See whether you, too, don't find it eminently suitable.

*Documentation on request

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ATARAX
in any hyperemotive state

for childhood behavior disorders
10 mg. tablets—3-6 years, one tablet t.i.d.; over 6 years, two tablets t.i.d. Syrup—3-6 years, one tsp. t.i.d.; over 6 years, two tsp. t.i.d.

for adult tension and anxiety
25 mg. tablets—one tablet q.i.d. Syrup—one tbsp. q.i.d.

for severe emotional disturbances
100 mg. tablets—one tablet t.i.d.

for adult psychiatric and emotional emergencies
Parenteral Solution—25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

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"care of the man rather than merely his stomach"[8]

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two-level control of gastrointestinal dysfunction

Miltown® + *anticholinergic*

at the central level The tranquilizer Miltown® reduces anxiety and tension.[1, 3, 6, 7] Unlike the barbiturates, it does not impair mental or physical efficiency.[5, 7]

at the peripheral level The anticholinergic tridihexethyl iodide reduces hypermotility and hypersecretion.

Unlike the belladonna alkaloids, it rarely produces dry mouth or blurred vision.[2, 4]

indications: peptic ulcer, spastic and irritable colon, esophageal spasm, G. I. symptoms of anxiety states.

each Milpath tablet contains:

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(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

Tridihexethyl iodide 25 mg.
(3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethiodide)

dosage: 1 tablet t.i.d. at mealtime and 2 tablets at bedtime.

available: bottles of 50 scored tablets.

references: 1. Altschul, A. and Billow, B.: The clinical use of meprobamate. (Miltown®). New York J. Med. 57: 2361, July 15, 1957. 2. Atwater, J. S.: The use of anticholinergic agents in peptic ulcer therapy. J. M. A. Georgia 45:421, Oct. 1956. 3. Borrus, J. C.: Study of effect of Miltown (2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate) on psychiatric states. J. A. M. A. 157:1596, April 30, 1955. 4. Cayer, D.: Prolonged anticholinergic therapy of duodenal ulcer. Am. J. Digest. Dis. 1:301, July 1956. 5. Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Experimental studies of behavioral effects of meprobamate on normal subjects. Ann. New York Acad. Sc. 67:701, May 9, 1957. 6. Phillips, R. E.: Use of meprobamate (Miltown®) for the treatment of emotional disorders. Am. Pract. & Digest Treat. 7:1573, Oct. 1956. 7. Selling, L. S.: A clinical study of Miltown®, a new tranquillizing agent. J. Clin. & Exper. Psychopath. 17:7, March 1956. 8. Wolf, S. and Wolff, H. G.: Human Gastric Function, Oxford University Press, New York, 1947.

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well tolerated, relatively nontoxic / no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness / well suited for prolonged therapy

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DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods. Should be adjusted to individual requirements.

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who discovered and introduced Miltown, the originol meprobomote.



(Continued from page 873)

Course on Diseases of the Chest at the Grady Memorial Hospital in Atlanta, Ga., March 10-14, 1958. The most recent advances in the diagnosis and treatment of chest diseases, both medical and surgical, will be presented. The tuition fee is $75. A registration form for the course may be found on page 870 of this issue of The Journal.

Dr. Victor H. Witten of New York discussed "What's New in Dermatology" at the January meeting of the Jacksonville Dermatological Society held in the Marshall Taylor Doctors' Building at Jacksonville. Dr. Lauren M. Sompayrac of Jacksonville, president of the Society, presided. Dr. Witten, a native of Jacksonville, is co-editor of the "Yearbook of Dermatology" and an associate of Dr. Marion Sulzberger.

A meeting of the Air-Medics Association has been scheduled for April 20-21, 1958, at Houston, Texas. It is being held in connection with the 91st Annual Session of the Texas Medical Association. Information may be obtained from Dr. C. F. Miller, secretary-treasurer, P. O. Box 1338, Waco, Texas.

BIRTHS AND DEATHS

Births

Dr. and Mrs. John I. Williams, of Fort Lauderdale, announce the birth of a son, John Irving Jr., on November 7, 1957.

Marriages

Dr. Cabell Young Jr., of West Palm Beach, and Miss Nancy Ellen Matthews, of Leaksville, N. C., were married November 16, 1957, in Leaksville.

Deaths — Other Doctors

Ginsburg, Samuel, DeBary.....September 12, 1957
Hodge, Otto Phillip, St. Petersburg.....August 28, 1957
Elder, James Franklin, Ormond Beach.....October 2, 1957
Beam, Eugene Cecil, Sarasota.....October 11, 1957

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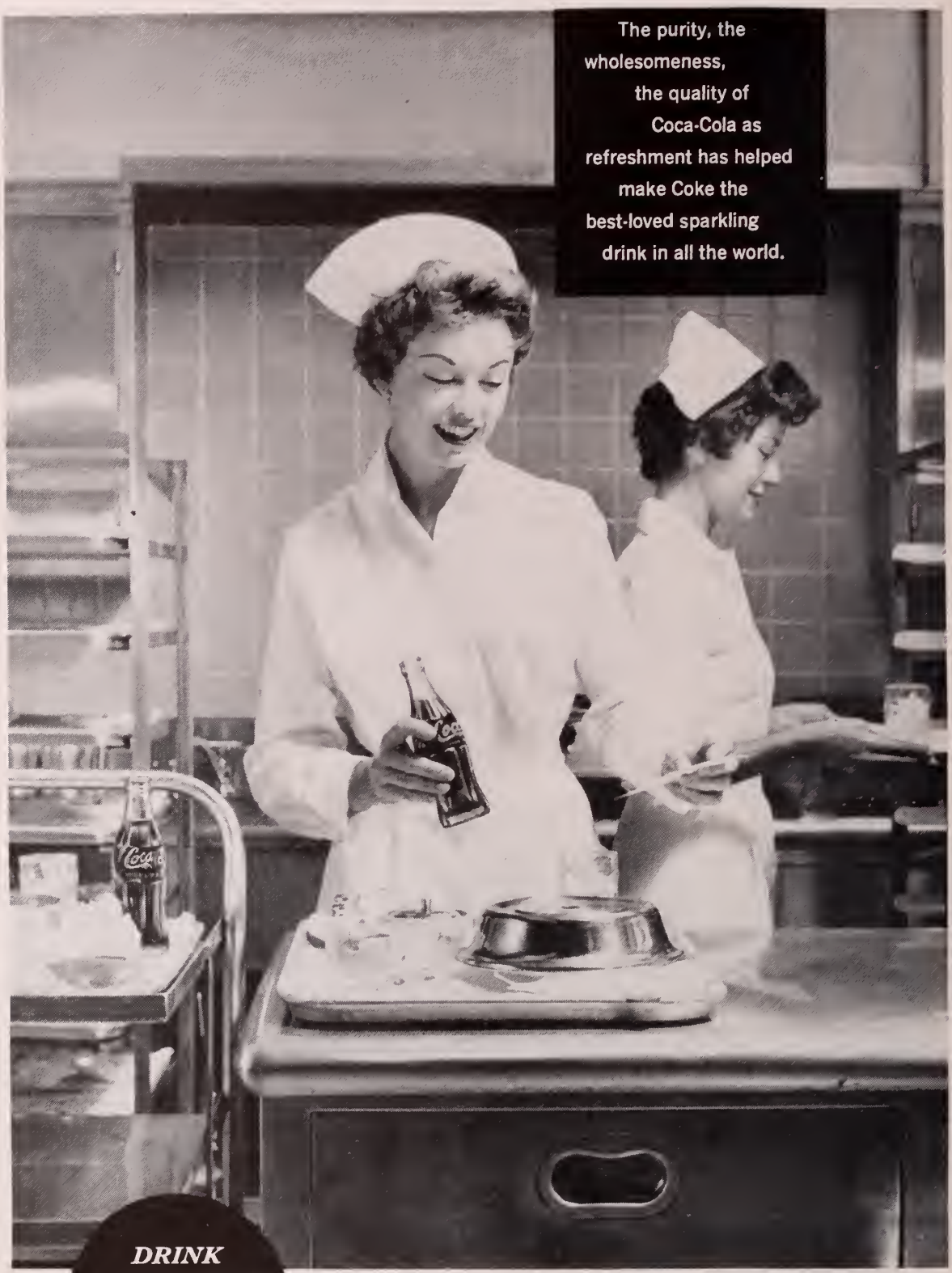
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COMPONENT SOCIETY NOTES

Alachua

Dr. G. Leonard Emmel has been installed as president of the Alachua County Medical Society for the year 1958. Dr. George H. Putnam has been chosen president-elect. Other officers recently elected include Dr. Charles H. Gilliland, vice president, and Dr. Eugene H. Cummings, secretary-treasurer. All are from Gainesville.

Brevard

Dr. Jack T. Bechtel, of Eau Gallie, has been elected president of the Brevard County Medical Society. Serving with Dr. Bechtel will be Dr. Louis C. Jensen Jr., of Rockledge, vice president, and Dr. Cyrus E. Warden, of Melbourne, secretary-treasurer. Dr. Jensen served as secretary-treasurer during 1957.

Broward

Dr. Russell R. Hippensteel, of Hollywood, has been installed as president of the Broward County Medical Association. Dr. Hippensteel served the Association as president-elect last year. Dr. Garland M. Johnson, of Fort Lauderdale, has been re-elected secretary.

Columbia

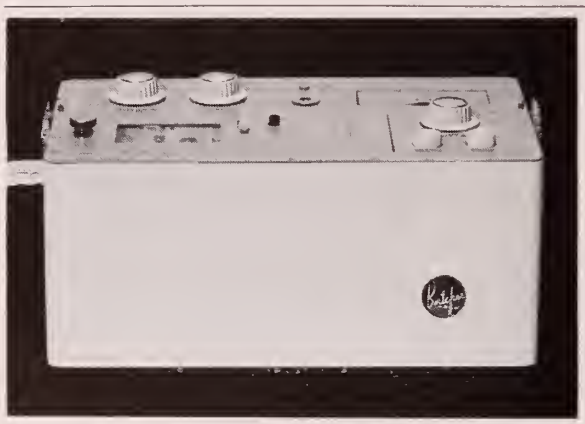
Dr. Robert M. Sasso is serving as president of the Columbia County Medical Society following his election at the recent annual meeting. Serving with Dr. Sasso will be Dr. Harry S. Howell, as vice president, and Dr. Louis G. Landrum, secretary-treasurer. All the officers are from Lake City.

Collier

Dr. Reider Trygstad, of Naples, has been elected president of the Collier County Medical Society. Dr. John J. Meli, of Naples, has been chosen vice president, and Dr. Loral F. Gwaltney, of Naples, treasurer. Dr. Ethel G. Trygstad, also of Naples, has been re-elected secretary.

Dade

Dr. Nelson Zivitz, of Miami, has been installed as president of the Dade County Medical Association. Chosen president-elect at the recent annual meeting was Dr. Robert P. Keiser, of Coral Gables. Other newly elected officers of the Association are Dr. Franklin J. Evans, of Coral Gables, vice president; Dr. Francis N. Cooke, of Miami, treasurer, and Dr. George W. Robertson III, of Miami, secretary.



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Duval

Dr. Ashbel C. Williams has been installed as president of the Duval County Medical Society. Dr. Samuel M. Day has been chosen president-elect. Elected at the recent annual meeting to serve with Drs. Williams and Day were Dr. Frederick H. Bowen, vice president; Dr. William J. Knauer Jr., secretary, and Dr. Sidney Stillman, treasurer. All are from Jacksonville.

Escambia

Dr. Joseph W. Douglas has begun serving as president of the Escambia County Medical Society following installation ceremonies at the Society's annual meeting. Dr. Egbert V. Anderson, president-elect, Dr. J. Melvin Young, vice president, and Dr. Joseph Q. Perry, secretary, are the other new officers of the Society who will be serving during 1958. All are from Pensacola.

Franklin-Gulf

Dr. William F. Wager, of Port St. Joe, has been elected president of the Franklin-Gulf County Medical Society. Dr. Wager served as secretary last year. Dr. Joseph P. Hendrix, also of Port St. Joe, has been chosen vice president, and Dr. Photis J. Nichols, of Apalachicola, secretary.

Hillsborough

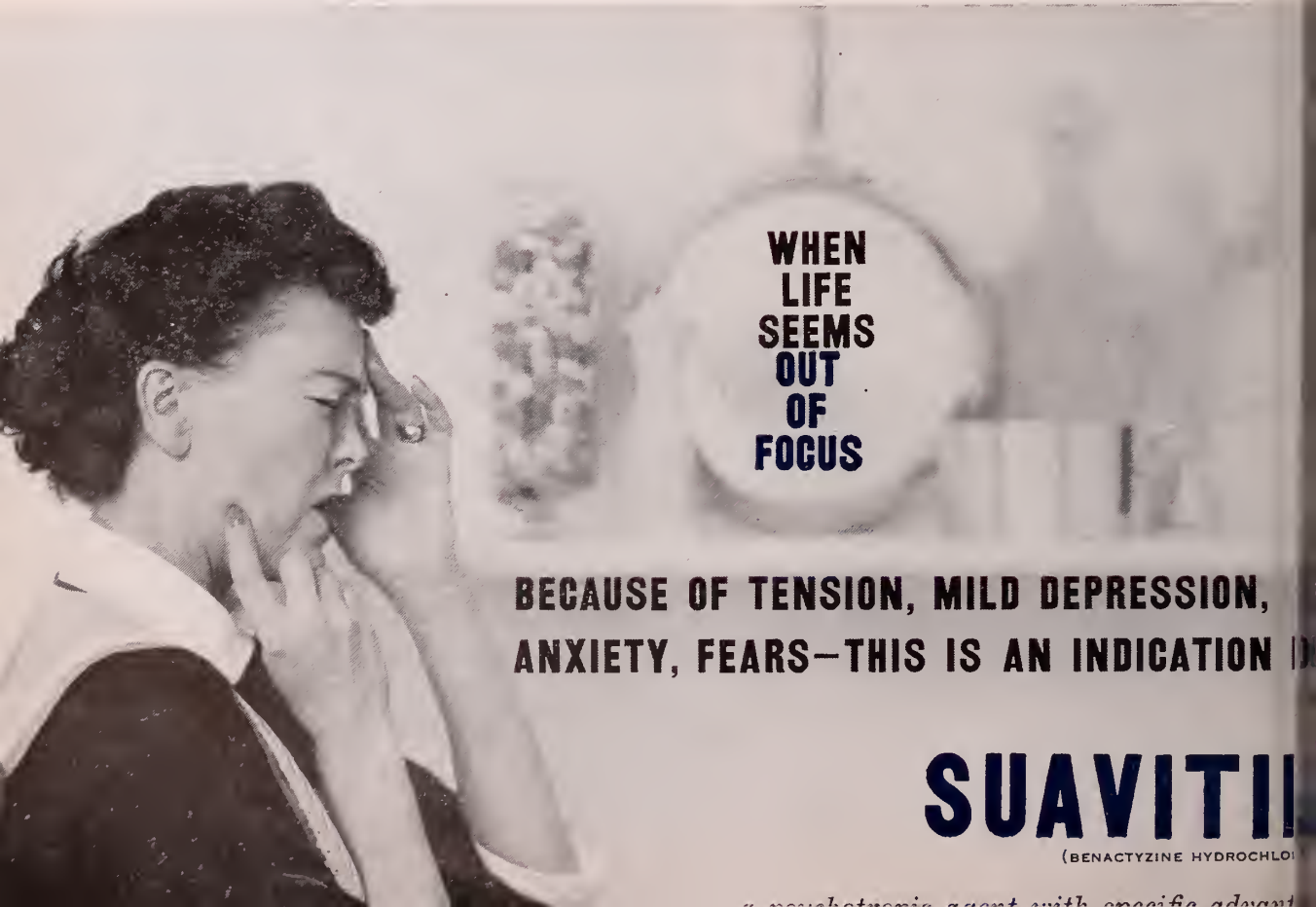
Dr. Wesley W. Wilson, who served as president-elect during 1957 has been installed president of the Hillsborough County Medical Association. Dr. Harold G. Nix has been chosen president-elect. First vice president is Dr. Charles L. Pope and second vice president is Dr. Frank H. Lindeman Jr. Dr. Marvin B. Miller is the newly elected treasurer. Dr. James A. Winslow Jr. was re-elected secretary. All are from Tampa.

Jackson-Calhoun

Dr. Sarah M. Schulz, of Marianna, has been elected president of the Jackson-Calhoun County Medical Society. Dr. Glenn E. Padgett has been chosen vice president and Dr. Francis M. Watson has been re-elected secretary-treasurer. Drs. Padgett and Watson are also from Marianna.

Lake

Dr. George E. Engelhard, of Leesburg, has begun serving as president of the Lake County Medical Society following his election at the Society's annual meeting. Serving with Dr. Engelhard are Dr. Lawton F. Douglass, of Umatilla, vice president, and Dr. Frederick C. Andrews, of Mount Dora, secretary-treasurer.



Leon-Gadsden-Liberty-Wakulla-Jefferson

Dr. T. Bert Fletcher Jr. has been elected president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. Dr. Odis G. Kendrick Jr. will serve with Dr. Fletcher as vice president, and Dr. Nelson H. Kraeft as secretary-treasurer. Dr. Kraeft was re-elected. All are from Tallahassee.

Manatee

Dr. Eugene E. Biel has been elected president of the Manatee County Medical Society. Dr. Albert A. Simkus is the Society's new vice president. Serving with Drs. Biel and Simkus is Dr. Irving E. Hall Jr., as secretary-treasurer. The officers are from Bradenton.

Marion

Dr. Harry M. Edwards has been installed as president of the Marion County Medical Society. Installed with Dr. Edwards were Dr. Harry S. Gibboney Jr. as vice president and Dr. Charles H. Marks as secretary-treasurer. Drs. Edwards, Gibboney and Marks are from Ocala.

Monroe

Dr. William R. Ploss has been elected president of the Monroe County Medical Society. Dr. Joseph J. Scarlet, who served as secretary during 1957, has been elected vice president. The Society's new secretary-treasurer is Dr. Walter R. McCook. All the officers are from Key West.

Orange

Dr. Robert E. Zellner has been installed as president of the Orange County Medical Society. Chosen president-elect at the Society's annual meeting was Dr. Robert L. Tolle who will assume the duties of president at the end of 1958. Dr. John J. Scanlon has been elected vice president; Dr. Charles R. Sias, treasurer, Dr. Robert W. Curry, secretary, and Dr. Benjamin Glaser, reporter. Drs. Zellner, Tolle, Curry, Sias and Glaser are from Orlando; Dr. Scanlon is from Winter Garden.

Palm Beach

Dr. W. Lawson Shackelford, of West Palm Beach, has begun serving as president of the Palm Beach County Medical Society following installation ceremonies at the Society's recent annual meeting. Dr. Younger A. Staton, also of West Palm Beach, has been chosen president-elect to take office at the end of 1958. Other officers include Dr. Fred E. Manulis, of Palm Beach, vice

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TIL helps patients recover normal drive and
s free them from compulsive fixations.

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If necessary this dosage may be gradually
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president, Dr. Willard F. Ande, of West Palm Beach, treasurer, and Dr. Robert Y. Wheelihan, of Riviera Beach, secretary. Dr. Wheelihan was re-elected.

Pasco-Hernando-Citrus

Dr. S. Carnes Harvard, of Brooksville, has been elected president of the Pasco-Hernando-Citrus County Medical Society. Serving with Dr. Harvard will be Dr. Dwayne L. Deal, of Dade City, and Dr. Alfred G. Brown Jr., of Inverness, as vice presidents, and Dr. W. Wardlow Jones, of Dade City, who was re-elected secretary-treasurer.

Pinellas

Dr. Whitman H. McConnell, of St. Petersburg, has been installed president of the Pinellas County Medical Society. Chosen to serve with Dr. McConnell at the Society's annual meeting were Dr. Rowland E. Wood, of St. Petersburg, president-elect; Dr. Julio J. Guerra, of Clearwater, first vice president; Dr. Edward L. Cole Jr., of St. Petersburg, second vice president, and Dr. Whitman C. McConnell, of St. Petersburg, secretary-treasurer. Dr. Whitman C. McConnell was re-elected.

Polk

Dr. Marion W. Hester, of Lakeland, has been installed as president of the Polk County Medical Association. Chosen president-elect at the Society's recent annual meeting was Dr. Newell J. Griffith, of Winter Haven. Dr. John E. Daughtrey, of Lakeland, was elected vice president, and Dr. Charles Larsen Jr., also of Lakeland, was re-elected secretary-treasurer.

Sarasota

Dr. Karl R. Rolls has been elected president of the Sarasota County Medical Society. Dr. Millard B. White has been chosen as treasurer, and Dr. James E. Kicklighter has been re-elected secretary. All are from Sarasota.

Seminole

Dr. Daniel H. Mathers is the new president of the Seminole County Medical Society. Elected to serve with Dr. Mathers was Dr. Vann Parker as vice president. Dr. Terry Bird was re-elected secretary-treasurer. Drs. Mathers, Parker and Bird are from Sanford.

Suwannee-Hamilton-Lafayette

Dr. Irby H. Black, of Live Oak, has been elected president of the Suwannee-Hamilton-Lafayette County Medical Society. Dr. William P.

(Continued on page 892)

For Real Pain ...give real relief:

A.P.C. WITH Demerol® tablets

Each tablet contains:

Aspirin	200 mg. (3 grains)
Phenacetin	150 mg. (2½ grains)
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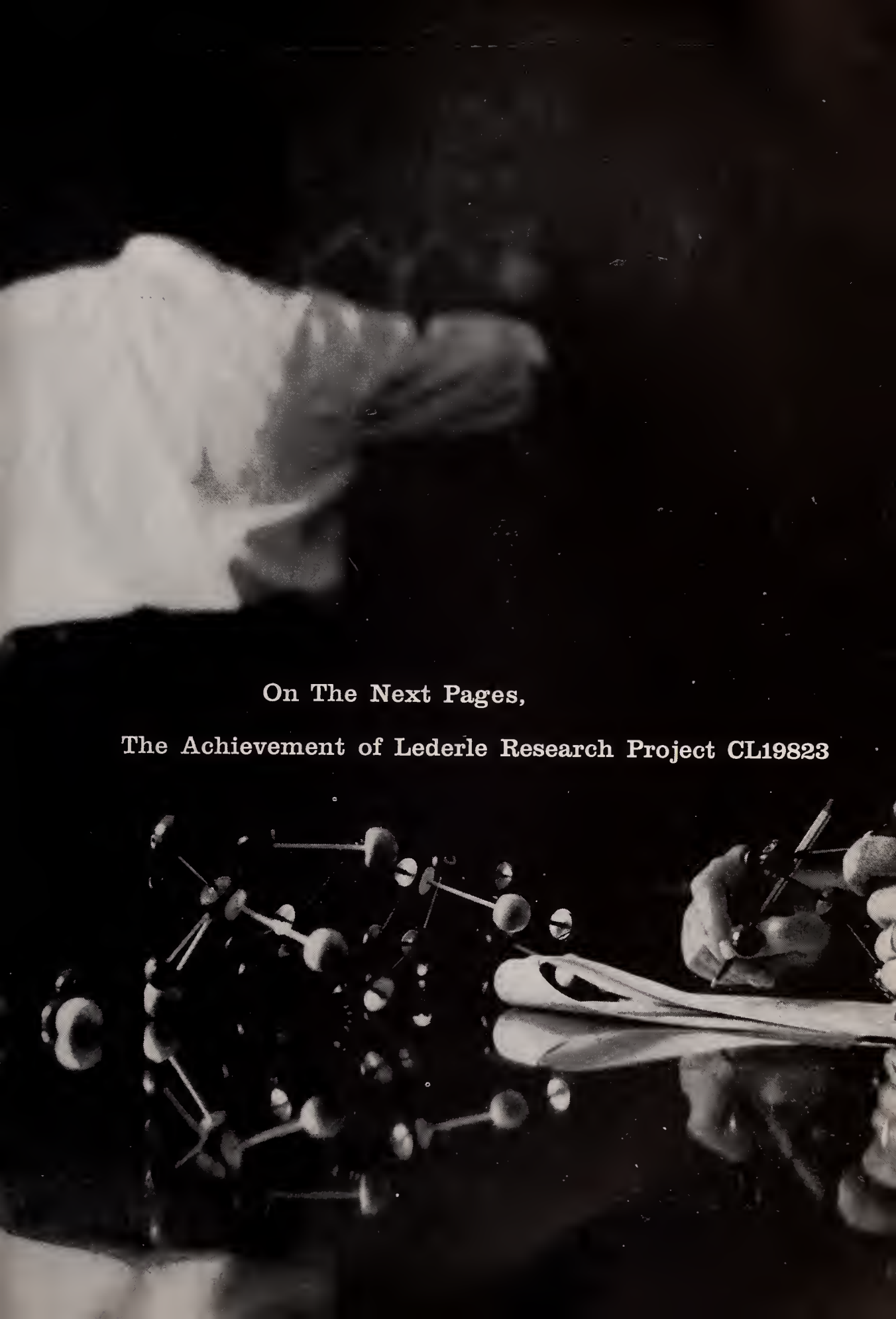
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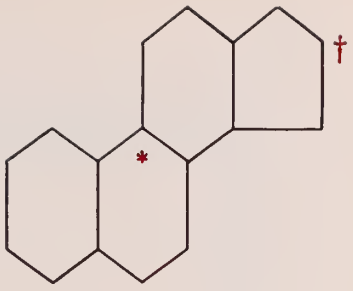
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Copper	0.2 mg.	Zinc	1 mg.
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Vitamin D	400 I.U.	Methionine	20 mg.
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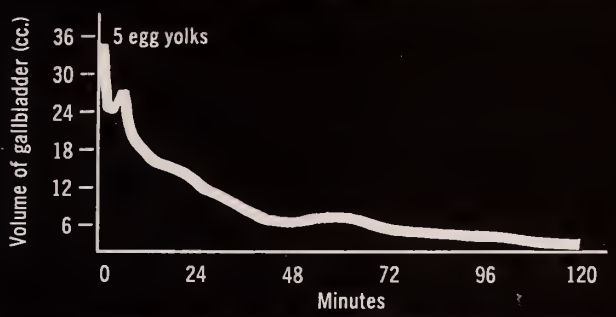
*REFERENCE: J.A.M.A. 163: 359, 1957 (February 2)

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*Adapted from Wright, S.: Applied Physiology, ed. 8, London, Oxford University Press, 1947, p. 734.

What's wrong with the term "emptying of the gallbladder"?

The gallbladder discharges bile by fractional evacuation. It is not emptied completely at any one time even following a fatty meal.

Source—Lichtman, S. S.: Diseases of the Liver, Gallbladder and Bile Ducts, ed. 3, Philadelphia, Lea & Febiger, 1953, vol. 2, p. 1177.

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DECHOLIN® one tablet t.i.d.
therapeutic bile

increases bile flow and gallbladder function—combats bile stasis and concentration... helps thin gallbladder contents.

corrects constipation without catharsis—prevents colonic dehydration and hard stools... provides effective physiologic stimulant.

DECHOLIN tablets (dehydrocholic acid, AMES) 3¾ gr. Bottles of 100 and 500.

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(Continued from page 886)

Blackmon, of Jasper, who served as secretary-treasurer during 1957, has been chosen vice president, and Dr. Hugo F. Sotolongo, of Live Oak, secretary-treasurer.

Volusia

Dr. Achille A. Monaco, of Daytona Beach, has been elected president of the Volusia County Medical Society. He previously served as secretary-treasurer. Also elected during the recent annual meeting were Dr. Robert O. Burry, of DeLand, as vice president, and Dr. John J. Cheleden, of Daytona Beach, secretary-treasurer.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bilotta, Laurence A., Winter Park
Bond, James W., Jacksonville
Bryan, Donald M., St. Petersburg
Campbell, Alan B. Jr., St. Petersburg
Crews, Frederick F., Fort Walton Beach
Derry, William H., Miami
Erdman, Leonard A., Fort Lauderdale
Fixel, Irving E., Hollywood
Folsom, John H. Jr., Orlando
Foss, Harold G., South Miami
Gates, Kermit H., Coral Gables
Griffin, Joseph A., South Miami
Gilbert, J. C. Jr., Fort Lauderdale
Gurinsky, Abraham, Miami
Harris, Harry, Miami
Huntley, Earl S. Jr., Miami
Kibler, Gordon E., Jacksonville
LaRue, Raymond A., Winter Haven
McCreary, Albert B., St. Petersburg
McDaniel, Grover C. Jr., Fort Lauderdale
Marrero, Emilio J., Jay
Ragona, Robert F., Hollywood
Rawlings, Joseph E. Jr., St. Petersburg
Rogers, Alexander S., Hollywood
Sanford, Marshall C., Fort Lauderdale
Sporn, Hyman, Hollywood
Swink, Robert L., Miami
vanBoven, John III, Palm Beach
Weisman, Joseph C., Orlando
Wells, Leonard R. Jr., Lake City
Williams, Thomas C. Jr., Crestview
Wold, Keith C., Fort Lauderdale
Zucker, Reuben, Orlando

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"freezes," weakens and kills even the most viable sperm

The unique sperm-trapping matrix formed with explosive speed when semen meets IMMOLIN® Vaginal Cream-Jel accounts for the outstanding effectiveness of this *new* contraceptive for use without diaphragm.

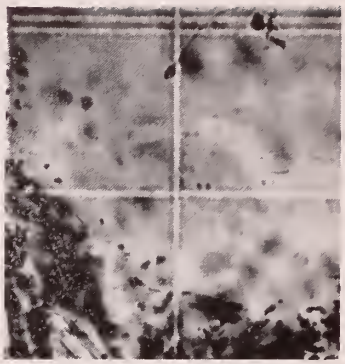
These unusual pictures, taken at high speed and magnification, show the IMMOLIN matrix in action — how a single sperm "freezes," weakens and dies — *within the distance it normally travels in one-quarter of a second.*

DEPENDABLE WITHOUT DIAPHRAGM—With this new contraceptive technique, a pregnancy rate of 2.01 per 100 woman-years of exposure is reported.* "This extremely low pregnancy rate indicates that IMMOLIN Cream-Jel used without an occlusive device is an efficient and dependable contraceptive."

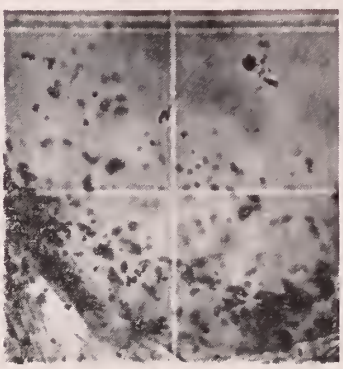
*Goldstein, L. Z.: Obst. & Gynec. *10*:133 (Aug.) 1957.

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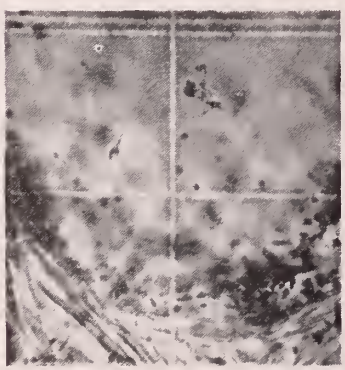
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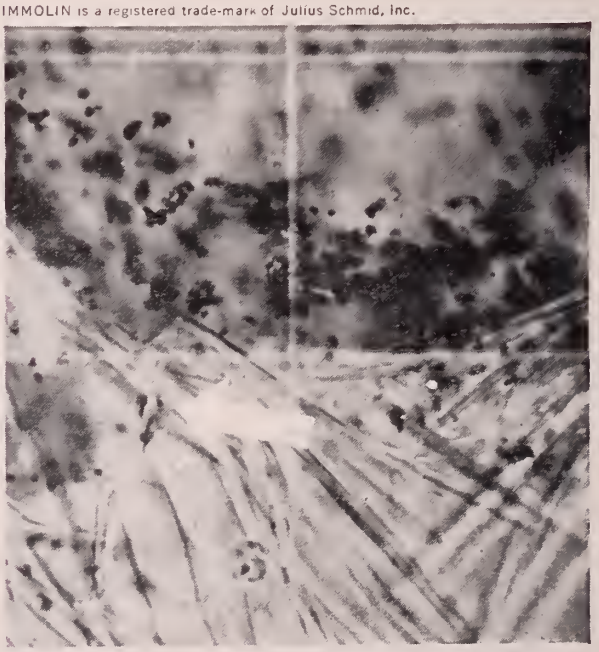
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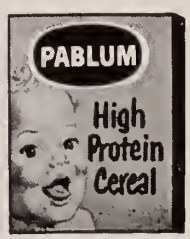


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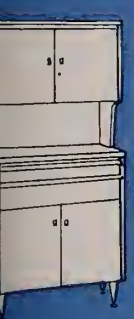
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NEW DOSAGE

The recommended adult dose is 1 Gm. (2 tablets or 4 teaspoonfuls of syrup) the first day, followed by 0.5 Gm. (1 tablet or 2 teaspoonfuls of syrup) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

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Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup:
Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

[1] Nichols, R. L. and Finland, M.: J. Clin. Med. 49:410, 1957.

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OBITUARIES

Walter Duval Webb

Dr. Walter Duval Webb of St. Augustine died in a local hospital on June 11, 1957, of coronary heart disease. He was 84 years of age. Interment took place in Arlington National Cemetery.

Born in Mankato, Minn., on June 15, 1872, Dr. Webb was graduated from Columbia University College of Physicians and Surgeons in New York City in 1895. He was a veteran of the Spanish-American War and World War I. He entered the medical corps of the United States Army in 1900; retired with the rank of major in January 1909; returned to active duty from February 1917 to September 1918; retired with the rank of colonel under the Act of June 21, 1930; and returned to active duty in December 1940 to

(Continued on page 906)

a Major Breakthrough in EDEMA— in HYPERTENSION



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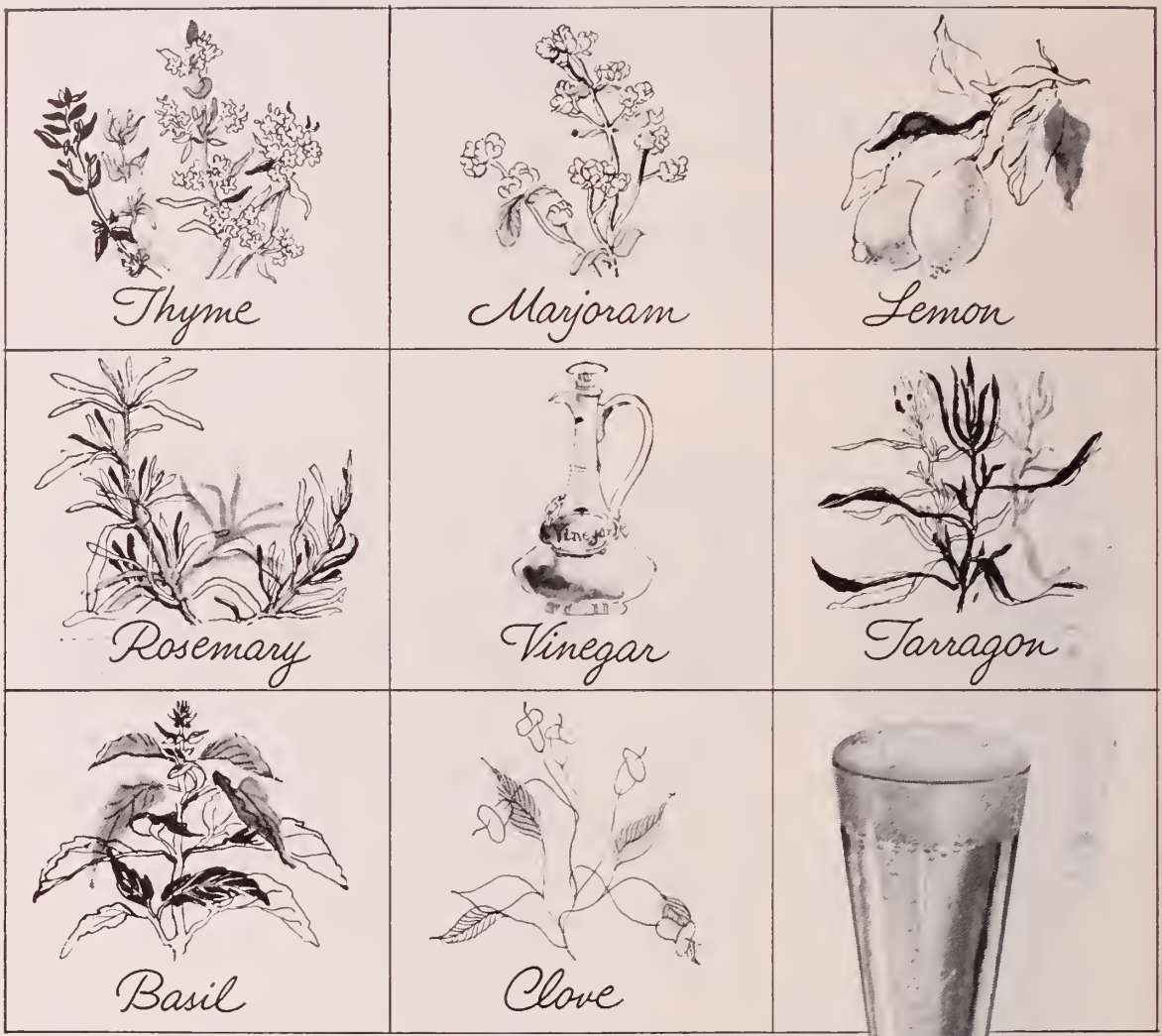
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The Low Sodium Diet

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Thyme, marjoram and pepper add zest to hamburger. Chicken's delicious with lemon, rosemary and sweet butter to baste. He can try sweet butter with nutmeg on green beans, savory on limas, tarragon with carrots, basil with tomatoes. Onions boiled with whole clove and thyme delight the taste of an epicure!

With these flavor tricks to add zest to his meals—and a glass of beer* now and then, at your discretion, your patient has a diet that's both good tasting and good for him.

*Sodium: 7 mg./100 gm., 17 mg./8 oz. glass (Average of American Beers)

—and a glass of beer, with your consent for a morale-booster

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relief in minutes..lasts for hours

In the common cold, nasal allergies, sinusitis, and postnasal drip, one timed-release Triaminic tablet brings welcome relief of symptoms *in minutes*. Running noses stop, clogged noses open—and *stay* open for 6 to 8 hours. The patient can breathe again.

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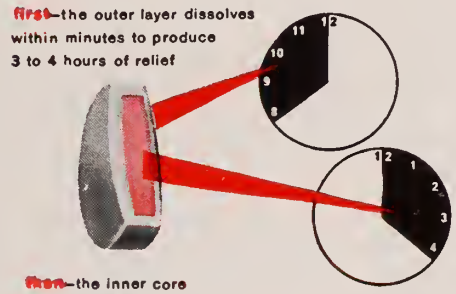
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

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Pentylenetetrazol . . 100 mg.
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1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954



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(Continued from page 900)

August 1946. During World War II he was head of the medical department for Selective Service in the State of Florida.

Upon entering the Army in 1898, Dr. Webb served three years in the Philippines and also served in Puerto Rico and Cuba. He was in charge of reconstruction following the San Francisco earthquake, and at one time served on the faculty of Georgetown University School of Medicine in Washington, D. C., as professor of oral surgery and lecturer in military surgery. In World War I he was in command of the hospital unit in Vichi, France, and an officer of the Legion of Honor; Knight of France at Claremont Feran; and was made a knight by General Danton. He was a member of the Society of Cincinnati of New York State.

This distinguished surgeon was a member of St. Johns County Medical Society. He had held membership in the Florida Medical Association since 1924. He was a life member of the American College of Surgeons.

Surviving are the widow, Mrs. Esther Webb, of St. Augustine; three daughters, Mrs. Margaret Walton, of California, Miss Francie Webb, of Arizona, and Mrs. Elizabeth Woody, of Richmond, Va.; and two sons, Creighton Webb, of St. Augustine, and Walter D. Webb Jr., of California.

Cleveland Jackson Price

Dr. Cleveland Jackson Price of Alford died at Clay County Hospital in Fort Gaines, Ga., on Aug. 23, 1957, of heart disease following a long illness. He was 68 years of age.

The son of Henry Wilson Price and Mary Ann Jenkins Price, Dr. Price was born in Louisville, Ala., on May 11, 1889. He received his academic training at Alabama Polytechnic Institute in Auburn, Ala., and was awarded his medical degree by the Atlanta College of Physicians and Surgeons, now Emory University School of Medicine, in Atlanta on June 8, 1913.

Dr. Price entered the private practice of medicine in Jackson County, Florida, in 1914 and continued to practice there until ill health forced him to retire in 1954. During World War I he served as examining physician for Selective Service.

Dr. Price was a member of the Jackson-Calhoun County Medical Society. He was a life member of the Florida Medical Association, holding

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1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

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honorary status at the time of his death, and also held membership in the American Medical Association.

Surviving are three daughters, Mrs. Clarence Morgan, Fort Gaines, Ga., Mrs. William Joseph Hoppers, Birmingham, Ala., and Mrs. John B. McKibbon Jr., Gainesville, Ga.; and by four grandchildren, William Joseph Hoppers Jr., Leonora Hoppers, Dawn McKibbon, and John B. McKibbon, III.

Lee Wolfe Lerner

Dr. Lee Wolfe Lerner of Miami died suddenly on July 4, 1957. He was 59 years of age.

Born in Quebec, Canada, on Aug. 3, 1897, Dr. Lerner received his medical degree from McGill University Faculty of Medicine in Montreal, Canada, in 1919. Before locating in Miami in 1952, he practiced general medicine and general surgery in New York City, where he was a member of the Bronx County Medical Society and the Medical Society of the State of New York.

Dr. Lerner was a member of the Dade County Medical Association and since 1954 had held membership in the Florida Medical Association. He was also a member of the American Medical Association and the American College of Surgeons.

The widow, Mrs. Ruth Lerner, of Miami, survives. Also surviving are a daughter, Carol, and a brother and three sisters.

BOOKS RECEIVED

Dermatologic Formulary: *New York Skin and Cancer Unit.* Frances Pascher, M.D., Editor. Ed. 2. Pp. 172. Price, $4.00. New York, Paul B. Hoeber, Inc., 1957.

This newly and completely revised second edition of this Formulary from the New York Skin and Cancer Unit, Service of Dermatology, of which Dr. Marion B. Sulzberger is director, was impelled not only by continuing demand after exhaustion of the first edition but especially by the tremendous therapeutic advances of the last three years. Dr. Sulzberger, who is George Miller MacKee Professor of Dermatology and Syphilology, New York University—Bellevue Medical Center, writes in the Preface that one of the main purposes in publishing this Formulary is to serve the practitioner by listing the most tried and useful dermatologic prescriptions, together with the briefest and simplest explanations of their uses, indications, and contraindications. An additional objective is to supply a model dermatologic formulary from which other hospitals, clinics, and institutions can, according to their needs, select a longer or shorter list of standard preparations for the care of the multitudinous sufferers from skin diseases. He stresses that the preparations included in this book are the product of the actual composite experience gained by leading teachers of dermatol-

(Continued on page 916)

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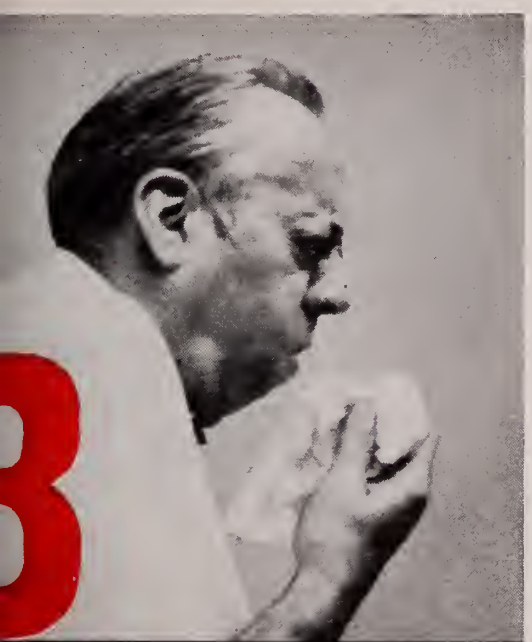
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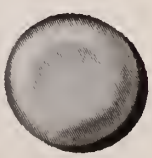
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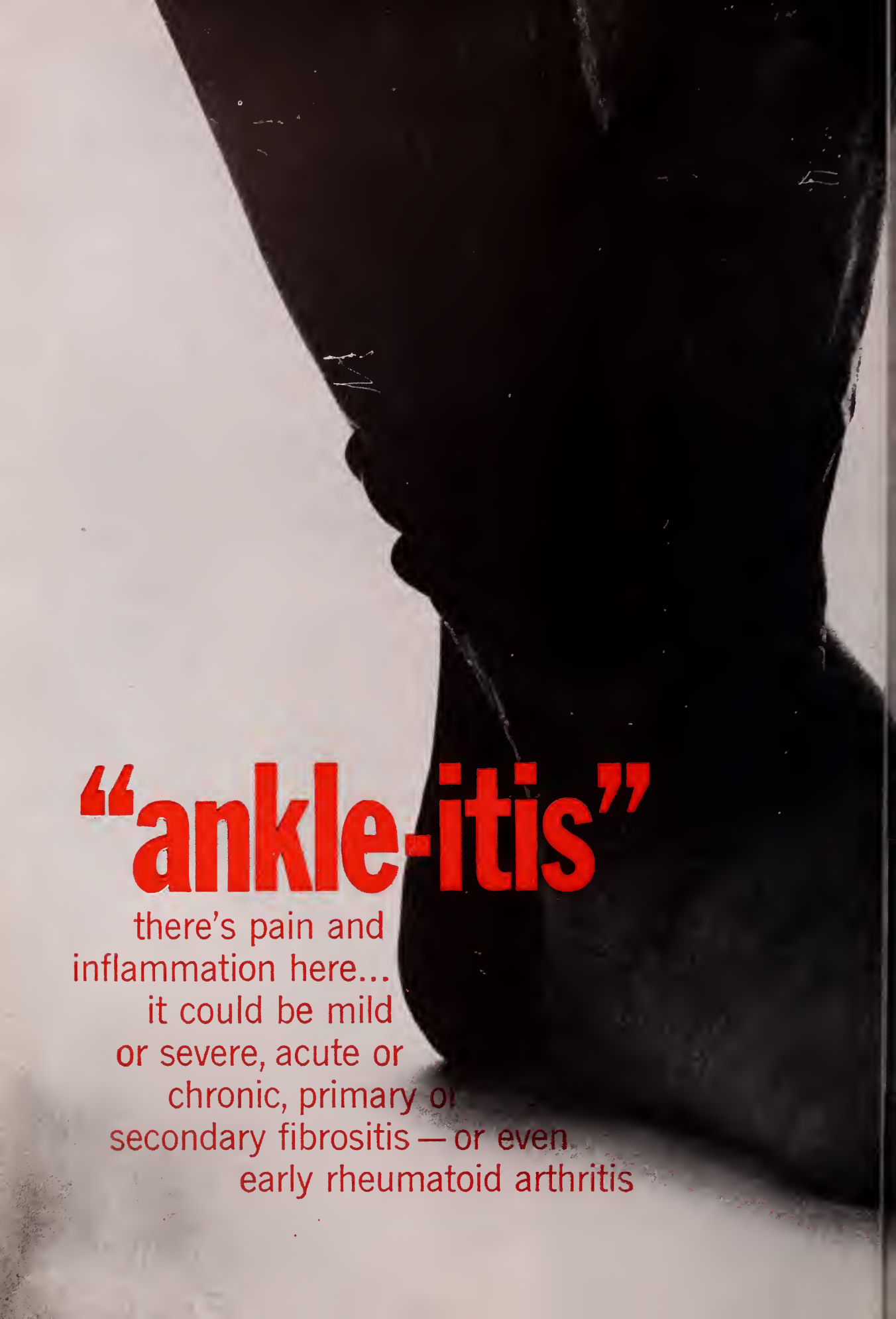
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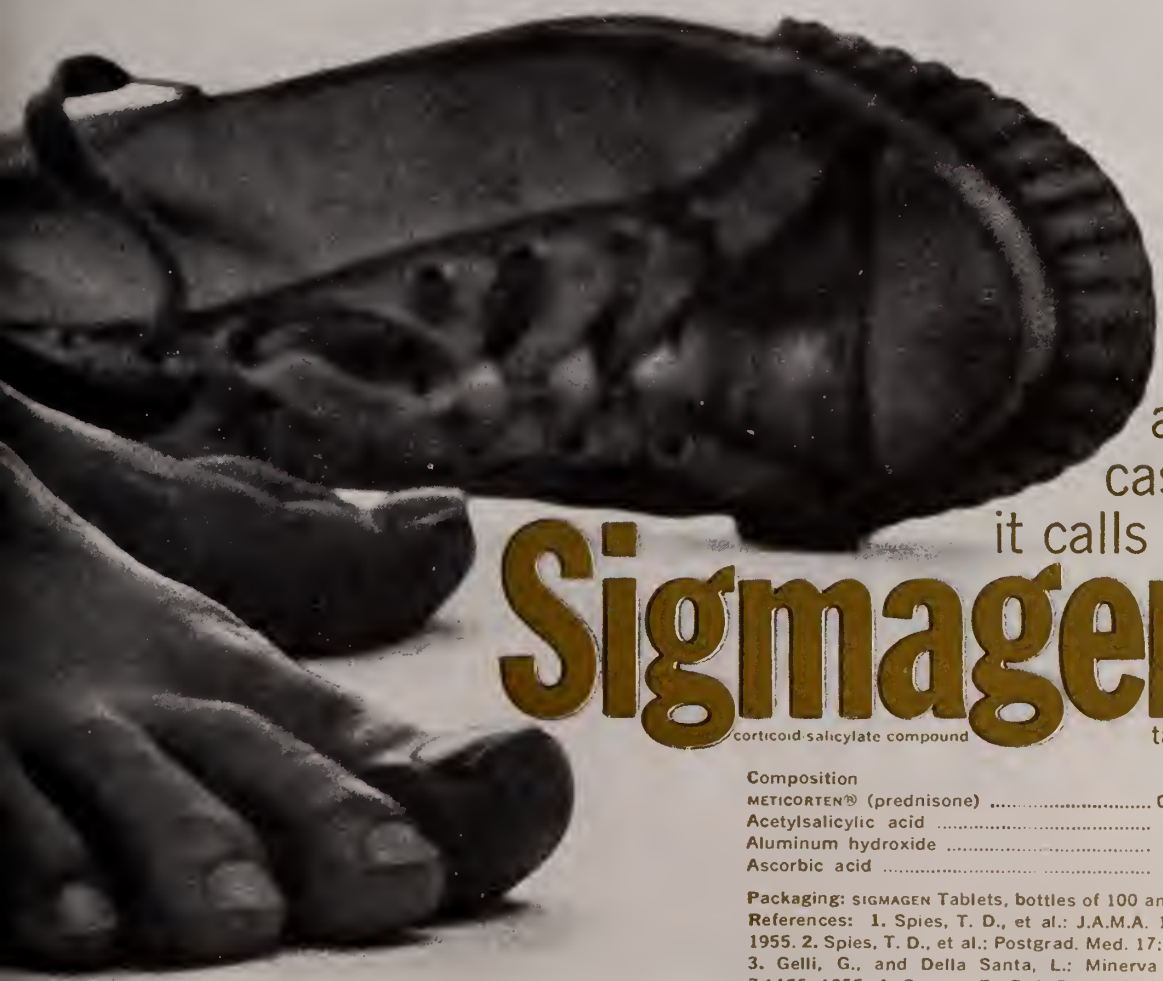
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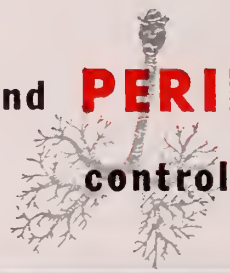
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(Continued from page 908)

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Practitioners' Conferences: *Held at The New York Hospital-Cornell Medical Center. Volume 6.* Edited by Claude E. Forkner, M.D., F.A.C.P. Pp. 378. Price, $6.75. New York, Appleton-Century-Crofts, Inc., 1957.

The present volume of the Practitioners' Conferences constitutes the sixth in the series and continues the policy of assembling in readily available form the best opinion available in the New York area on the subjects considered. As in the past, an effort has been made to keep these practical conferences on a clinical level but at the same time to balance them with panel members who represent the basic sciences. In this way these Conferences have attempted to provide a challenge for the clinician and a basis of understanding for the practicing physician.

The 15 panels covered in this volume were on: Should Patients Be Told the Truth About Serious Illness?; Trichinosis; Cancer of the Thyroid; Cancer of the Prostate; Cancer of the Esophagus; Tumors of the Lung; Portal Hypertension; Tumors of the Bone Other Than Multiple Myeloma; Early Detection of Heart Disease; Dermatophytosis, Tinea Capitis, and Monilia Infections of the Skin; Poison Ivy and Contact Dermatitis; Encephalitis and Parkinsonism; Endometriosis; Consultations with Anesthesiologists, and Gout. The panel members represented staff members of other hospitals and medical schools than those of The New York Hospital-Cornell Medical Center, thus promoting the presentation of diversified opinions, and the Conferences were focused on the physicians who were not members of the Cornell Medical Center, providing them with the advantages of a great teaching institution.

A Nurse Named Mary. By Alexander Matthews. Pp. 155. Price, $3.00. New York, Pageant Press, Inc., 1957.

This book is the heart-warming biographic account of the life of Mary Lathrop Wright Matthews, who will be remembered in Florida as Director of Nurses, Palm Beach County Health Department, West Palm Beach, a post she held for 16 years. Written after her untimely death in 1955 by her husband, Alexander Matthews, who is still a resident of West Palm Beach, the book tells the story of a woman whose devotion to serving the sick and helpless of all nations led her from the Kentucky foothills to Boulogne, France, during World War I, and from an isolated mission hospital in Shanghai, China, to important pioneering work in this country in the field of public health. The main portion consists of a moving and highly engrossing diary kept by her while serving as an Army nurse in France during World War I. Included also are extracts from the 1926-1927 journal she kept while teaching student nurses for the Episcopal mission in Shanghai, and numerous public testimonials to her competence in the public health field, in which she was much revered.

The book is of particular interest to anyone interested in nursing, and women everywhere, regardless of profession, should find the story of the intrepid Mary Matthews a fine inspiration. The excerpts from her diary reveal her as a woman with boundless energy, devotion to duty, intelligence, and stoicism. More than that, it presents the thoroughly human story of one heroic woman's devotion to humanity, and as such should have universal appeal and value.

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Ciba Foundation Colloquia on Ageing, Volume 3, Methodology of the Study of Ageing. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc. Pp. 202. Illus. 47. Price, $6.50. Boston, Little, Brown and Company, 1957.

This volume contains the proceedings of the third colloquium in a series of three conferences organized by the trustees of the Ciba Foundation to encourage laboratory and clinical investigations relative to the problems of aging. In view of the many long term schemes for the observation of changes with age in man and whole animals that were under way or about to begin in various centers, it was thought useful on this third occasion to examine the methodology of such investigations.

A few of the many topics covered are: methodology of the study of intelligence and emotion in aging; methodological problems in the study of changes in human performance with age; use of inbred strains of animals in experimental gerontology; study of the aging of cells; methods and limitations in studies of human organ system function; and examples of reactions to standard stimuli at different ages.

Ciba Foundation Colloquia on Endocrinology. Volume 10. Regulation and Mode of Action of Thyroid Hormones. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Elaine C. P. Millar, A.H.-WC., A.R.I.C. Pp. 311. Illus. 114. Price, $8.50. Boston, Little, Brown and Company, 1957.

During the last 10 to 15 years there has been enormous activity in the field of thyroid investigation, and for the first time the Ciba Foundation devotes a symposium to it. This volume attempts to take stock of the discoveries of this period by presenting formal papers from leading investigators the world over. These papers, and the informal discussions which follow, serve as a clearing house of ideas on the latest concepts of regulation of the thyroid gland on the one hand, and the character and mode of action of its hormones on the other.

One result of the spurt in thyroid research has been some divergence of opinion about a number of problems. The Ciba Foundation offers the participants an opportunity to air these differences and help resolve them by an exchange of information and by discussion.

A Woman Doctor Looks at Love and Life. By Dr. Marion Hilliard. Pp. 190. Price, $2.95. Garden City, N. Y., Doubleday & Company, Inc., 1957.

Women may be creatures of mystery to a man, but not to a wise and sympathetic doctor like Marion Hilliard, chief of obstetrics and gynecology at Women's College Hospital in Toronto, Canada. Dr. Hilliard has not only restored thousands of women to physical health but has also helped them to find the self knowledge which leads to inner peace and successful, zestful living. Whether a woman is frightened or simply perplexed or bothered by her problems, Dr. Hilliard gives her outspoken advice and realistic answers from her uniquely authoritative point of view as both woman and doctor. In her book, as in her office, she brings understanding to a woman, not by preaching, but through lively discussion. She shares her experiences. Then, through anecdotes and case histories, she frankly discusses the haunting unspoken fears that may ruin a life or wreck a marriage. Her topics are: A Woman's First Baby; What Should I Tell My Children?; Adolescence; Sex in Marriage; Open Letter to Husbands; Women's Fears; The Greatest Enemy—Fatigue; The Menopause; Old Age. Behind Dr. Hilliard's delightfully breezy, informal style of writing is a world of wisdom, which women of all ages will gratefully recognize and eagerly accept.

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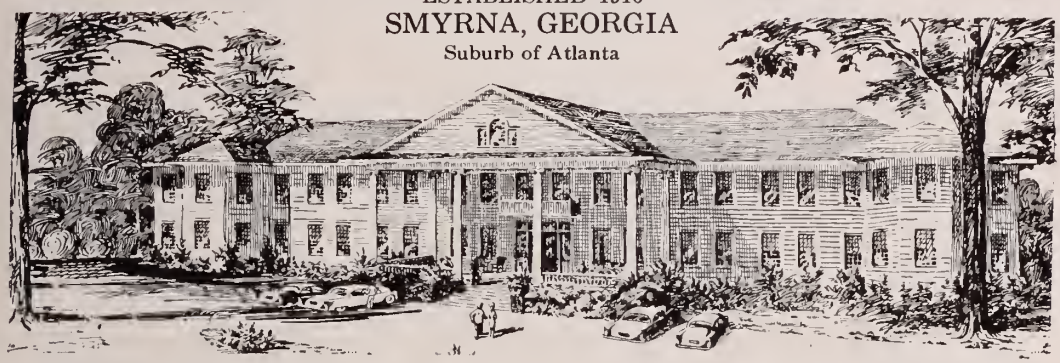
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Brevard	Jack T. Bechtel, Eau Gallie	Cyrus E. Warden, Melbourne	2nd Tues.	53
Broward	Russell R. Hippensteel, Hollywood	Garland M. Johnson, Ft. Lauderdale	4th Tues.	182
Collier	Reidar Trygstad, Naples	Ethel H. Trygstad, Naples	3rd Wed.	9
Columbia	Robert M. Sasso, Lake City	Louis G. Landrum, Lake City	1st Mon.	11
* *Baker*				
Dade	Nelson Zivitz, Miami	Geo. W. Robertson III, Miami	1st Tues.	808
DeSoto-Hardee-Highlands-Glades	Charles H. Kirkpatrick, Arcadia	Gordon H. McSwain, Arcadia	1st Tues.	28
Duval	Ashbel C. Williams, Jacksonville	William J. Knauer Jr., Jacksonville	1st Tues.	334
* *Clay*				
Escambia	Joseph W. Douglas, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	113
Franklin-Gulf	William F. Wager, Port St. Joe	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	Wesley W. Wilson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	225
Indian River	Enoch J. Vann Jr., Vero Beach	Charles F. Rattray, Vero Beach	2nd Tues.	9
Jackson-Calhoun	Sarah M. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	15
Lake	Geo. E. Engelhard, Leesburg	Frederick C. Andrews, Mt. Dora	1st Wed.	26
* *Sumter*				
Lee-Charlotte-Hendry	Gustave F. Bieber, Ft. Myers	William M. Taylor, Ft. Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	T. Bert Fletcher Jr., Tallahassee	Nelson H. Kraeft, Tallahassee	3rd Mon.	72
Madison	Wilmer J. Coggins, Madison	Julian M. DuRant, Madison	Quarterly	8
Manatee	Eugene E. Biel, Bradenton	Irving E. Hall Jr., Bradenton	2nd Tues.	31
Marion	Harry M. Edwards, Ocala	Charles H. Marks, Ocala	3rd Tues.	33
* *Levy*				
Monroe	William R. Ploss, Key West	Walter R. McCook, Key West	1st Thurs.	13
Nassau			1st Thurs.	8
Orange	Robert E. Zellner, Orlando	Robert W. Curry, Orlando	3rd Wed.	219
* *Osceola*				
Palm Beach	W. Lawson Shackelford, W. Palm Bch.	Robert Y. Wheelihan, Riviera Bch.	4th Mon.	162
Pasco-Hernando-Citrus	S. Carnes Harvard, Brooksville	W. Wardlaw Jones, Dade City	2nd Thurs.	20
Pinellas	Whitman H. McConnell, St. Pete	Whitman C. McConnell, St. Pete	1st Mon.	253
Polk	Marion W. Hester, Lakeland	Charles Larsen Jr., Lakeland	2nd Wed.	111
Putnam	Bennie J. Massey, Palatka	Fairfax E. Montague, Palatka	2nd Tues.	10
St. Johns	Thomas L. Glennan, Green Cove Spgs.	Walter W. Weigel, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin			3rd Thurs.	29
Sarasota	Karl R. Rolls, Sarasota	James E. Kicklighter, Sarasota	2nd Tues.	67
Seminole	Daniel H. Mathers, Sanford	Terry Bird, Sanford	2nd Tues.	15
Suwannee-Hamilton-Lafayette	Irby H. Black, Live Oak	Hugo F. Sotolongo, Live Oak	1st Sat.	11
Taylor	John A. Dyal Jr., Perry	Charles R. Wiley, Perry	Last Fri.	6
* *Dixie*				
Volusia	Achille A. Monaco, Daytona Bch.	John J. Cheleden, Daytona Bch.	2nd Tues.	86
* *Flagler*				
Walton-Okaloosa-Santa Rosa	Howard A. Parker, Valparaiso	Eric F. Geiger, Milton	3rd Tues.	27
Washington-Holmes				3
			Total	3,154

* *Supervise and aid until organized separately.*

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Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension: Some Observations on Comparative Toxicity of Reserpine, a Single Alkaloid, and Alseroxylon, a Compound Containing Multiple Alkaloids, Postgrad. Med., January, 1958.



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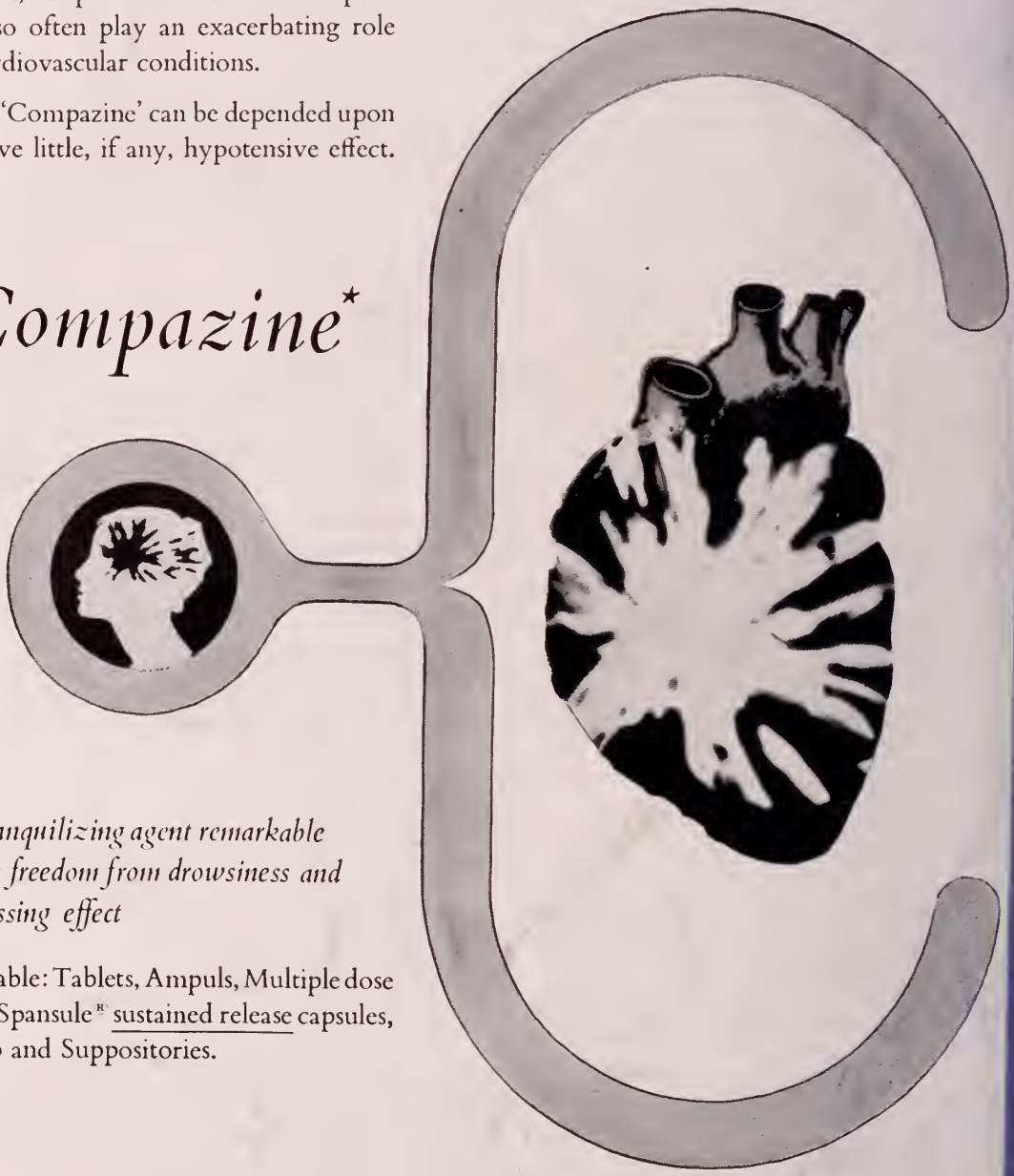
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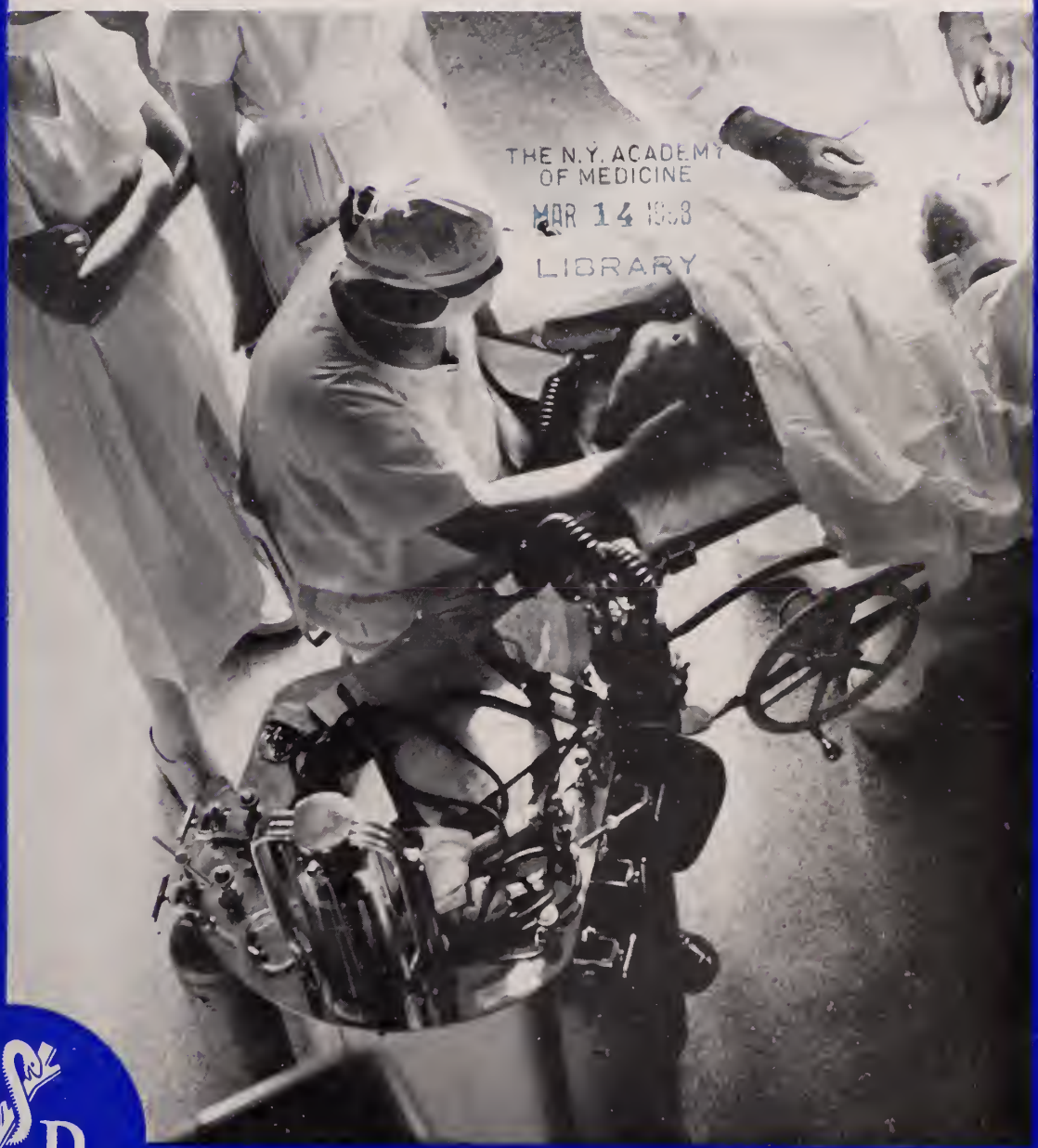
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The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLIV MARCH, 1958 No. 9



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SPECIFICALLY

for petit mal

and psychomotor seizures



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(methsuximide, Parke-Davis)









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Clinical experience[1,2,3] indicates that CELONTIN:

- provides effective control with minimal side effects in the treatment of petit mal and psychomotor epilepsy;
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1. Zimmerman, F. T., and Burgemeister, B.: *Arch. Neurol. & Psychiat.* 72:720, 1954.
2. Zimmerman, F. T., and Burgemeister, B.: J.A.M.A. 157:1194, 1955.
3. Zimmerman, F. T.: *Arch. Neurol. & Psychiat.* 76.65, 1956.



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for the petit mal triad

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VOLUME XLIV, No. 9 • *March, 1958*

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Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville Florida, October 23, 1924



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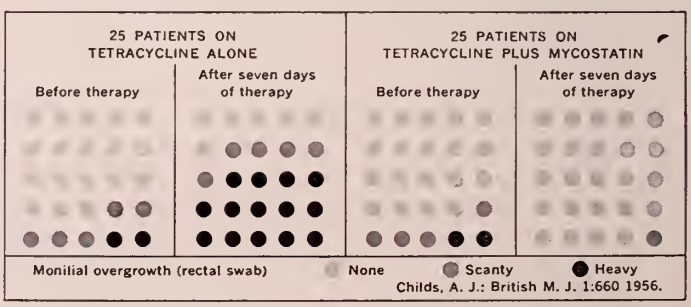
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Childs, A. J.: British M. J. 1:660 1956.

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Triaminic does not cause secondary congestion, eliminates local overtreatment and consequent nasal pathology.

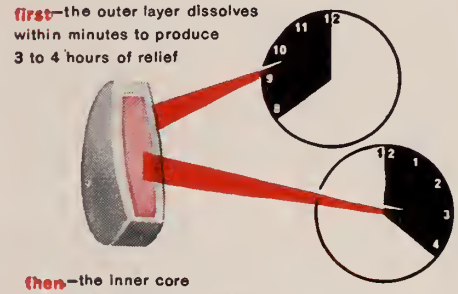
*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

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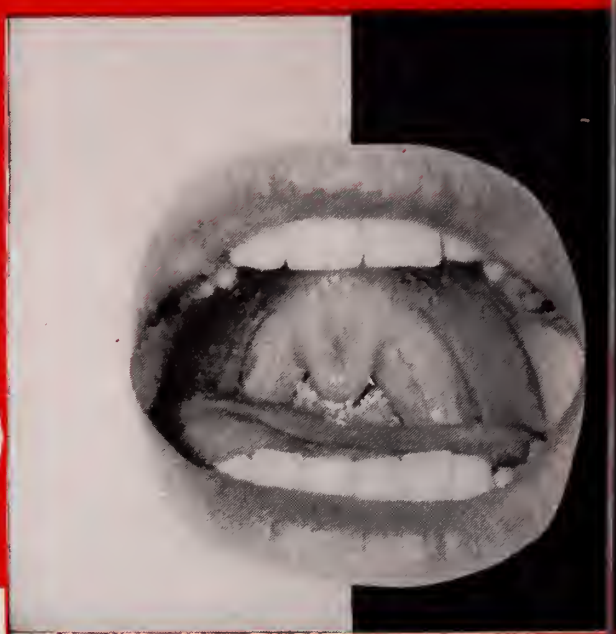
references: 1. Altschul, A. and Billow, B.: The clinical use of meprobamate. (Miltown®). New York J. Med. *57*: 2361, July 15, 1957. 2. Atwater, J. S.: The use of anticholinergic agents in peptic ulcer therapy. J. M. A. Georgia *45*:121, Oct. 1956. 3. Borrus, J. C.: Study of effect of Miltown (2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate) on psychiatric states. J. A. M. A. *157*:1596, April 30, 1955. 4. Cayer, D.: Prolonged anticholinergic therapy of duodenal ulcer. Am. J. Digest. Dis. *1*:301, July 1956. 5. Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Experimental studies of behavioral effects of meprobamate on normal subjects. Ann. New York Acad. Sc. *67*:701, May 9, 1957. 6. Phillips, R. E.: Use of meprobamate (Miltown®) for the treatment of emotional disorders. Am. Pract. & Digest Treat. *7*:1573, Oct. 1956. 7. Selling, L. S.: A clinical study of Miltown®, a new tranquilizing agent. J. Clin. & Exper. Psychopath. *17*:7, March 1956. 8. Wolf, S. and Wolff, H. G.: Human Gastric Function. Oxford University Press, New York, 1947.

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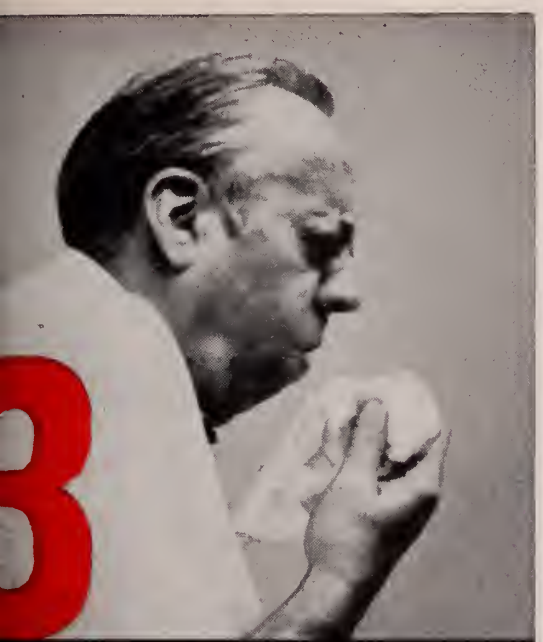
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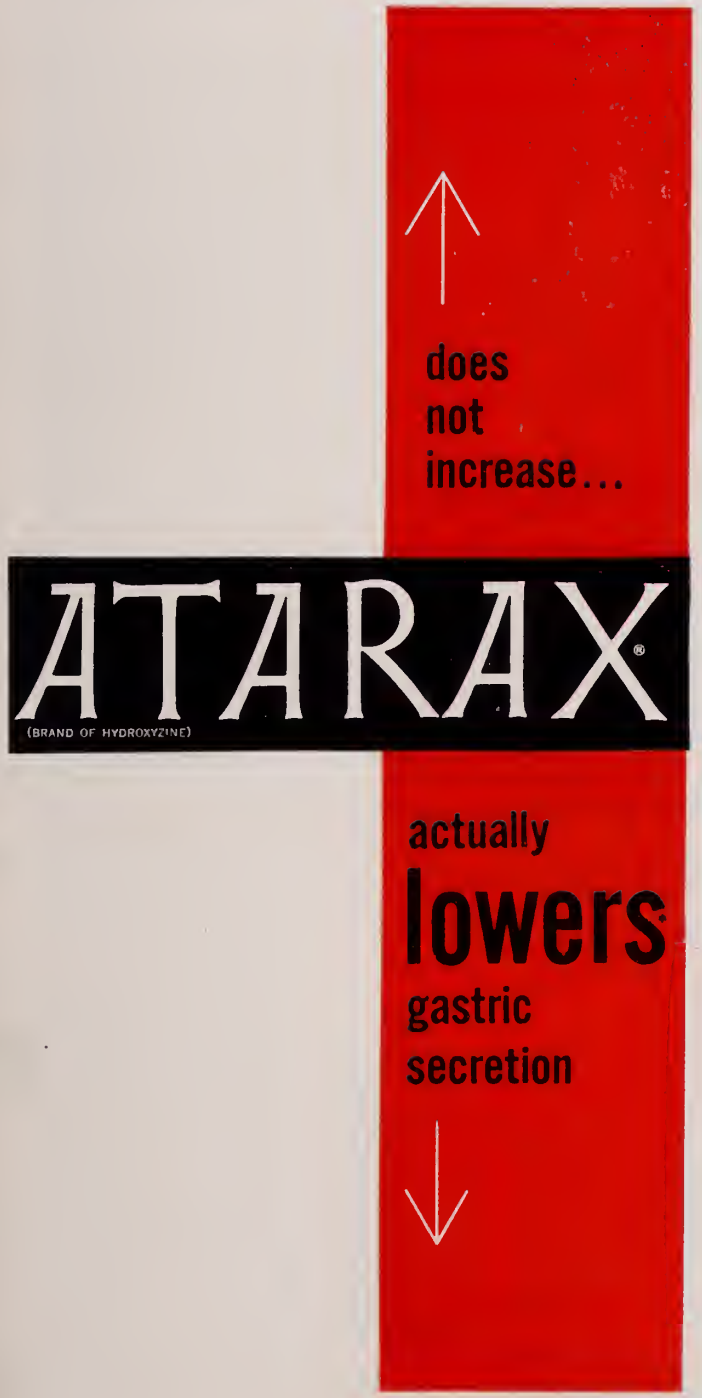
Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

*'Cardilate' brand Erythrol Tetranitrate SUBLINGUAL TABLETS, 15 mg. scored



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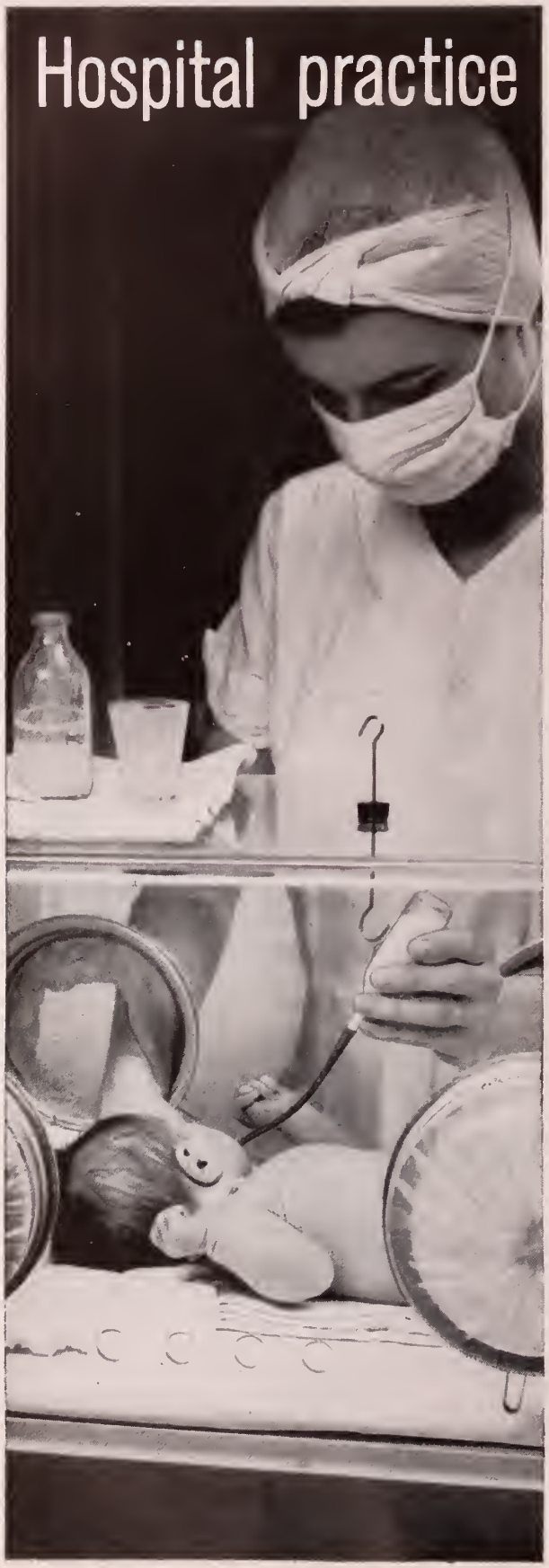
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4. Five dosage forms give you maximum flexibility.

supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

references: 1. Strub, I. H.: Personal communication. 2. Ayd, F. J., Jr.: presented at Ohio Assembly of General Practice, 7th Annual Scientific Assembly, Columbus, September 18-19, 1957.

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New York 17, New York
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(Feedings Started After 36 Hours and Continued at 2 to 3 Hour Intervals)

FEEDINGS	COMPOSITION	QUANTITY
First Six	5% Karo	2-5 ml.
7th and 8th	2 parts 5% Karo 1 part breast milk or formula	6-10 ml.
9th and 10th	1 part 5% Karo 1 part breast milk or formula	8-15 ml.
11th and 12th	1 part 5% Karo 2 parts breast milk or formula	10-18 ml.
Subsequently	Breast or formula feeding	12-20 ml.

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1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954



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The Journal of The Florida Medical Association
PUBLISHED MONTHLY

Volume XLIV | Jacksonville, Florida, March 1958 | No. 9

Facial Fractures: Their Recognition And Management

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JACKSONVILLE

Fractures of the facial bones are on the increase, due in large part to the automobile. It is estimated that they occur in 4 per cent of all automobile injuries. That figure means a total of 1,200 in Florida alone last year. When other causes such as athletics, domestic injuries and industrial accidents are included, it is apparent that these are injuries of some importance (fig. 1).

Diagnosis of these injuries is often confusing to the physician. To be sure, the cardinal symptoms and signs of fractures are present, namely, pain, displacement of bony continuity, abnormal movements, and the like, but the problem here is complicated by the excessive soft tissue swelling and the frequency of severe lacerations or head injuries which take precedence in treatment. Often, roentgenograms are the final diagnostic aid, but here again the interpretation of the roentgenograms is not easy to one inexperienced in this problem. An endeavor is here made to simplify the problem of diagnosis and conclude with a few words on treatment.

Diagnosis

An appreciation of the anatomy of the facial bones is invaluable (fig. 2). The facial bones are thin with numerous foramina and air cells and sinuses. These characteristics play a large part in determining the lines of fracture whereas the sponginess cushions most severe blows from injuring the cranial contents. Surgeons like to classify these fractures according to location. The facial skeleton is divided into horizontal thirds, upper, middle and lower. The middle third is subdivided into central and lateral elements. The major fractures follow closely this division and are governed by the direction and force of the blow.

Mandibular fractures are usually well recognized. The common sites of fracture are well known, namely, the condylar or subcondylar region, the symphysis or the angle. The causative factor is nearly always a direct blow, and the direction of the blow determines to large extent the site of the fracture. The mandible is a resilient V-shaped bone, and if it is fractured at any point and there is displacement present, then there must either be a second fracture or a dislocation of one of the condyles.

Recognition of fractures of the mandible is usually straightforward. The most obvious symptom is pain, which is usually localized at the site of fracture. A tender swelling is often palpated, and sometimes crepitus at the fracture line can be detected. An important diagnostic sign in this and all other fractures of the jaws is malocclusion. A tear in the gum may be seen at the site of fracture. Severe pain and trismus occur because of the action of the powerful muscles attached to the mandible. This is in contradistinction to the midfacial fractures, in which bruising and disfigurement are out of all proportion to the pain.

Midfacial fractures fall into the anatomic areas shown in the diagram (fig. 2).

Fractures of the outer third are those of the zygoma. If caused by a sharp object and received at the side, the arch will be fractured and displaced inwards. Oftentimes the depression on the side of the face is visible and readily palpable subcutaneously. If the inward angulation is severe, it impinges on the temporal fossa, narrowing it and producing anything from mild trismus to complete mechanical blockage to movement of the jaw.

If the patient is hit on the cheek, the body of the zygomatic bone fractures. It may collapse egg shell fashion into the maxillary antrum, or the entire eminence may displace as a pyramidal block. When the latter, there are always three fracture lines, along the zygomatic arch, near the zygomatic frontal suture, and along the infraorbital rim. There is always pronounced soft tis-

Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 7, 1957.

sue swelling. In the first type of injury flattening of the side of the face may be recognizable and palpable. In the second type, palpation with the fingernail along the bony ridges will reveal a tender irregularity or displacement at the fracture lines. The lower fracture line passes through the infraorbital foramen and causes contusion or avulsion of the nerve, associated with peripheral anesthesia of the upper lip and teeth on the same side. This is an important diagnostic sign. The degree of displacement varies. If severe, there is loss of support of the orbital floor, and diplopia, especially on lateral movements, is apparent.

Central middle third fractures are those involving the nose and the maxilla. Nasal fractures occurring alone are due to localized blows. The nasal bones and the septum are usually involved, rarely the frontal or maxillary processes. The nose may be flattened or displaced to one side or the other. The diagnosis is usually self evident and the extent of displacement more evident on clinical than on radiologic examination.



Fig. 1. — Upper. A severe face injury with underlying multiple facial fractures. Lower. The late result of an undetected left-sided facial fracture.

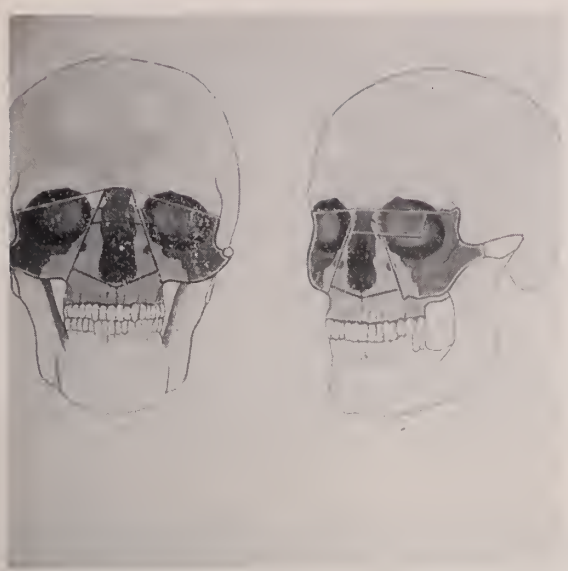


Fig. 2. — Normal anatomy of the midfacial bones showing common sites of fracture and the classification zones.



Fig. 3.—A normal Waters projection. This view shows the outline of the facial bone.

Maxillary fractures are the most complicated. The maxilla may fracture above the teeth when the blow is received on the mouth. The fragment shears off from the side walls of the antrum just above the root of the teeth and lies loose in the mouth. Occasionally, this lower fragment is complicated by a second fracture in the sagittal plane so that it lies loosely in two halves. Diagnosis is not difficult. The patient has an open bite. Intraoral examination shows the malocculsion and may reveal a laceration of the palate. If the upper jaw is grasped with the fingers, it can be moved independently of the maxilla. This is an important diagnostic sign in middle third injuries.

In the most severe injuries one is dealing with a complex of fractures. This is the patient who shows the dish-face appearance. The entire middle third of the face is pushed in, although in less severe cases the outer third malar bones are not displaced. On roentgen studies (fig. 6) the nasal bones are separated and splayed, there is bilateral malar fracture and horizontal fracture of the alveolar process of the upper jaw. In making the diagnosis prior to roentgen examination, it is helpful to remember the findings in the simple injuries and aggregate these. To summarize, a multiple injury will show open bite, mobility of the maxilla, broadening of the nasal bones, loss of the normal contour of the cheeks and total anesthesia of the midportion of the face.

Roentgenograms play a most important part in diagnosis, and a few words concerning their interpretation may be in order. The most valuable projection is the Waters (fig. 3). This view outlines the facial bones without undue overlapping. Points to note are the orbital rims, the zygomatic arches, the nasal bones and the normal translucency of the antrums. Fractures in the vicinity of the antrums are associated with hemorrhage, which shows up as an opacity on the roentgenogram (fig. 4).

Treatment

Initial efforts are directed to the management of complicating lacerations and head injuries. If

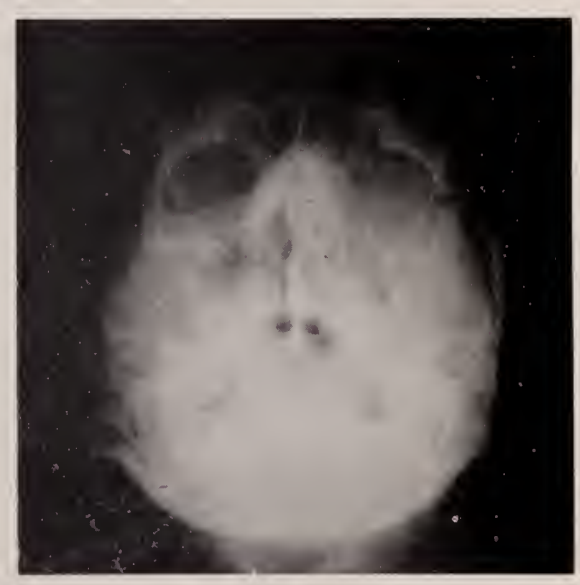


Fig. 4. — Fracture of the left malar region illustrating the antral opacity, the fracture lines through the orbital rim and the depression of the infraorbital margin.

the general condition permits, it may be possible to proceed with immediate reduction and fixation of the fractures, but as a rule no great urgency exists, and a delay of several days is of no great consequence. An exception is fractures of the mandible. In these latter, pain is common from movement at the fracture site, and the jaw should be supported early.

The aim of treatment is the reduction of any displacement and fixation until union has occurred. The technic will vary with the type and site of fracture.

In zygomatic fractures involving the arch, the fragments can often be hooked back into position with a towel clip passed through the cheek. If more extensive, and there is pronounced displacement of the zygoma, an incision is made in the temple through the temporal fascia, and an elevator is passed beneath the displaced fragment. The displaced block of bone is then elevated into place. It usually repositions like a keystone and remains stable. If the antral wall is flattened, it may be necessary to open the antrum and reposition the fragments with a sound or finger. Stability may require antral packing for about 10 days.

Treatment of fractures of the jaw is governed by the presence or absence of teeth. If teeth are present, interdental fixation by arch bars and rubber bands is simple and effective. The use of the bands permits readjustments of pull to correct



Fig. 5. — Case A. Upper photos show prereduction appearance three days after injury. Lower picture is patient's appearance three weeks after the operative reduction. The view to the right illustrates the arch bars and rubber band traction.

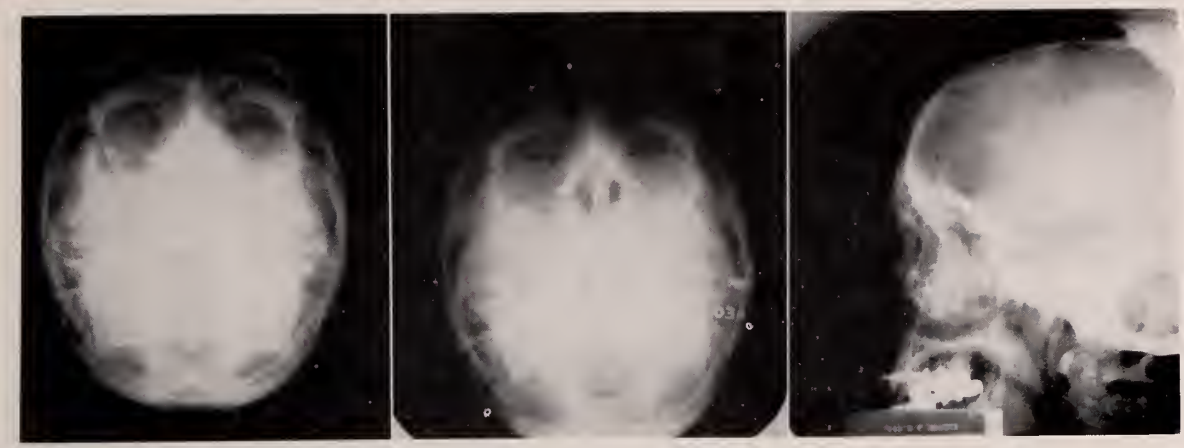


Fig. 6. — Case A. a. — Preoperative x-ray. b. c. — After reduction showing the internal wire fixation in position.

misalignment of teeth. Usually four to six weeks' immobilization is adequate. When no teeth are present in the lower jaw, fixation can be readily obtained by direct wiring of the fragments. This is accomplished easily through a small curved incision beneath the chin and over the fracture line.

Nasal fractures are easily disimpacted with an elevator passed into the nasal cavities and then molded into position between thumb and index finger. Intranasal packing and external splinting are often necessary for three to four days postoperatively.

The major problem is that of multiple middle third fractures. The breaks are often so extensive that there is no rigid support upon which to stabilize. My experience suggests that open reduction and internal fixation give excellent results with an easy convalescence. The advantages of direct wiring of fragments are the accuracy of repositioning and stability, especially when the wiring is attached to uninjured areas such as the frontal bone. The technic is not unduly difficult, it is not hazardous, and the patient is ambulatory the following day, unhindered by plaster head caps, cheek wires and other forms of external fixation. An illustrative case follows:

A 35 year old woman was injured in an automobile accident. A front seat passenger, she was thrown into the windshield and received severe facial lacerations as well as facial fractures. The lacerations were sutured immediately, and she was transferred five days later for treatment of the facial fractures. There was complete separation with inward displacement of the middle third of the facial skeleton (figs. 5 and 6). This was repositioned and stabilized by internal wire fixation supplemented by arch bar splintage of maxilla to mandible. Good reduction and stability were obtained. Convalescence was rapid, and she was discharged one week later. She is shown (fig. 5) two weeks following the fixation. Although there still remained considerable bruising, the patient was ambulant and able to attend to her housework.

Summary

An attempt is made to simplify the problem of diagnosis of fractures of the facial bones. This is based on an anatomic classification which has a practical clinical application. The methods of treatment described, based to large extent on open reduction and internal fixation, have as an aim a minimum of postreduction discomfort and disability for the patient. A typical severe injury is illustrated to support these beliefs.

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Discussion

Dr. Clifford C. Snyder, Miami: It is difficult to mention all phases of this problem, but Dr. Morgan has covered his subject well. In addition one might say that usually the fracture problem per se is not the emergency that an adequate airway or serious bleeding presents. Once the patient's respiratory exchange is satisfactory and major bleeding points are controlled, other traumatic complications should be looked for, such as soft tissue injury, nerve severance, parotid duct injury, ocular perforation, fractured skull or other bone damage.

If there is soft tissue avulsion or irregular skin lacerations, these may be closed at the time of the facial fracture treatment or repaired later. Debridement and cleansing of wounds and simple repair are always acceptable. In cases in which the eyelids, lips, nose or ears are damaged, one may concentrate on meticulous approximation if the patient's condition permits. Hematomas must be prevented. If a main branch of the facial nerve is injured, it should be repaired, but terminal branches are left alone. When the parotid salivary duct is severed, there is no better time to approximate it than at the time of initial surgery. Whenever an ocular injury is present, an ophthalmalogist should be called immediately.

I utilize the same methods that Dr. Morgan employs in treating the facial bone fractures. My acquaintance with the Adam's method of wiring for maxillary fractures eliminates any plaster head dressing, though the latter is practiced by many surgeons.

Diet is an important subject in regard to after-care because solid foods not only are difficult to take but also

may cause complications. A free liquid intake with added protein and vitamin supplementation serves the purpose adequately.

DR. JOSEPH E. O'MALLEY, Orlando: I wish to thank Dr. Morgan for the opportunity to review this fine paper.

Facial fractures are indeed on the increase, particularly so with the increasing popularity of the two wheel motor-driven vehicles such as the motor scooter. Three of my most recent and severe cases occurred in teenagers, traveling at a high rate of speed and completely unprotected on scooters. There is usually massive avulsion of the facial tissues associated with multiple facial fractures in this type of injury and oftentimes total loss of portions of the facial skeleton.

This paper gives an excellent review of the important factors in diagnosis of the most commonly encountered fractures. Regarding fractures of the mandible in particular, I should like to emphasize the importance of dental occlusion. One should familiarize oneself with correct occlusion as this serves as a guide in the reduction of fractures and provides a positive index for re-establishing the masticatory power of the teeth. When occlusion is re-established, the bone fragments are in good functional alignment. This is important from a diagnostic standpoint, for in some instances, undisplaced fractures at the angle, particularly, can be devoid of clinical findings unless considerable force is applied to create pain or crepitus. The only aid in diagnosis prior to roentgen examination is the patient's statement that his teeth do not seem to come together properly.

It is not surprising how often a fracture of the zygomatic bone is overlooked and treatment neglected. Dr. Morgan has emphasized that edema and discoloration far overshadow pain in fractures of the middle plane of the face, and this factor is a considerable hindrance in diagnosis when associated with multiple facial lacerations. Pronounced periorbital edema makes palpation about the rim of the orbit most difficult, and one must rely on roentgen examination in the absence of trismus, pronounced facial depression and diplopia. If diplopia is elicited on examination, one should always suspect a fracture at the frontozygomatic suture, allowing the lateral canthus of the eye to be displaced downward.

I certainly agree with Dr. Morgan that the various maxillary fractures are the most complicated and, when associated with single or multiple fractures of the mandible, can be a real challenge to the surgeon from both a functional and cosmetic standpoint. His review of the useful diagnostic signs was most adequate and, if followed, should reveal a fracture in this area.

The important factors in treatment were well covered, and I should like to add one method in the management of the markedly comminuted and displaced fracture of the mandible in the dentulous and certainly in the edentulous patient. Reduction and satisfactory immobilization can be accomplished by the use of a stout Kirschner wire driven by a high speed electric drill through the marrow cavity of the mandible on all fractures of the mandible other than those of the coronoid process or within the temporal mandibular joint itself. It has been my practice to use this method under direct vision by means of a small incision directly over the site of fracture, driving the wire out through the distal fragment and back into the proximal fragment. This procedure does not require any immobilization between the maxilla and mandible, a consideration which is particularly important in the aged and debilitated, allowing them to eat normally and maintaining adequate nutrition as the fracture heals. The main objection to this procedure in the past has been the possibility of permanent injury to the inferior alveolar nerve. This can be prevented by drilling the wire under direct vision with a minimum of trauma to the marrow cavity and most accurate repositioning of the fragments.

Dr. Morgan's method of reduction and immobilization of the fragments of the maxilla is an excellent one, and I agree that direct wiring of the fragments is the method of choice to obtain accuracy of repositioning and stability.

DR. GEORGE W. ROBERTSON III, Miami: Dr. Morgan has presented most adequately a problem of which we see a great deal. Unfortunately, recognition of many of the facial fractures occurs too late to effect a primary repair. The fracture is often marked by edema, hematoma, or ecchymosis, and not until swelling has disappeared is the deformity usually visualized or the diplopia noted.

As in many fields of medicine, a high index of suspicion is necessary to make the diagnosis. Although the plastic surgeon generally has this index, it is necessary to continue to stress the facial fracture problem to the traumatic surgeons and the neurosurgeons in order to treat these problems primarily. The primary repair is simpler and less involved than the later introduction of grafts or implants for the improvement of the deformity.

Correction

On page 810 of the February issue of The Journal, the cut used in reproducing Figure 1 is reversed, with what should be the top shown as the bottom. The illustration, Figure 1, is a part of the paper "Transplantation of the Ureters Into an Isolated Ileal Loop," by J. Harold Newman, M.D.

Recurrent Intussusception in a Six Year Old Child With Histoplasmosis of Peyer's Patches

Manuel G. Carmona, M.D.
and
Marvin S. Allen, M.D.
Hollywood

The purpose of this paper is to review the diagnostic problems encountered and to report a single but unusually interesting case of recurrent intussusception with complete recovery following two operations.

Report of Case

A six year old white male child was admitted to Memorial Hospital in Hollywood on Jan. 22, 1956 as a private patient of one of us (M.G.C.), complaining of abdominal pain of three hours' duration. The father of the child stated that the pain developed around the epigastrium and later moved on down to the right lower quadrant of the abdomen. The pain was steady; at intervals it appeared to get worse and then it would subside again. At the peak of the pain, the patient would vomit stomach contents. There had been no irregularities in bowel movements; the last bowel movement was normal and took place the morning he entered the hospital. He had experienced no fever, no chills and no symptoms referable to the urinary tract.

The child had had measles and chickenpox. Aside from these diseases, he has enjoyed good health until the present time.

The parents were divorced, and the child was in custody of the father, a police officer in this area. The remainder of the family history was irrelevant.

The child was examined by one of us (M.G.C.) in the emergency room at Memorial Hospital. The examination gave essentially negative results except for moderate tenderness and a slight rigidity in the abdomen, limited to the right lower quadrant and most pronounced over McBurney's point. There were no palpable masses or organs. Examination of the remainder of the abdomen gave negative results, as did rectal examination, and there was no mucus or tarry stool on the gloved finger.

A blood count showed 17,000 white blood cells with 76 segmented forms, 3 stabs forms, 20 lymphocytes and 1 eosinophil. The urinalysis gave entirely negative evidence.

A presumptive diagnosis of acute appendicitis was therefore made, and the patient was operated upon shortly after he was admitted to the hospital. The abdomen was explored through a right McBurney's incision, and on opening of the peritoneal cavity about 300 cc. of bloody fluid was expressed. The ileum was distended, and on following it proximally, it was found to be telescoped through the ileocecal valve for a distance of about 1 foot. The McBurney's incision was enlarged, and the intussusception was reduced manually, without too much difficulty, in the usual manner by pushing gently on the intussuscipiens. When reduced, the bowel wall was found to be grossly hemorrhagic with much clotted blood underneath the serosa. By means of hot saline packs directly over the areas of hemorrhage, the viability of the bowel was determined. The bowel was watched for a period of about 30 minutes, at the end of which time it was put back into the peritoneal cavity. No prophylactic procedures to prevent future recurrence of the intussusception were carried out. The appendix was somewhat swollen and indurated and it was removed for fear an acute suppuration might ensue. The wound was repaired in layers, using No. 1 chromic catgut, and black silk for the skin.

The pathologic report was: "(1) Acute appendicitis; the appendix was found edematous from early acute inflammation. (2) Pinworm infestation; the lumen was packed with pinworms."

The postoperative course was uneventful. While the child was in the hospital, one of us (M.S.A.) of the Pediatric Service of Memorial Hospital gave the child a course of Antepar to get rid of the pin worms. Blood counts and urinalysis were repeated, giving results within normal limits. Throughout the postoperative period the child received Combiotic, 2 cc. every 12 hours for a period of three days and then 2 cc. daily until he was discharged from the hospital on the seventh postoperative day. His father was told that at any time in the future, should the child experience abdominal pain, he should be taken to the doctor immediately as intussusception was known to recur.

While at home the child got along well. He tolerated his diet and was having normal bowel movements and enjoying complete recovery.

Seventeen days after the first operation, the child became suddenly ill about 11:30 p.m. This time he was complaining of severe intermittent abdominal pains and vomiting. He was brought back to the emergency room of the hospital, and one of us (M.G.C.) was again called to see the patient. The pain had now been present for one and a half hours and was in both the epigastrium and the right lower quadrant. It came in acute episodes, during which the child would sit up on the stretcher, tap his abdomen hard and at times grab it, crying in severe pain and doubling his legs up on his abdomen. Then he would start vomiting clear stomach contents. The pain would last two or three minutes and then subside; the child would then be able to lie down again.

Examination again was essentially negative except for the abdomen. There was moderate tenderness of the entire lower portion of the abdomen, especially in the right lower quadrant under the recent McBurney's scar. No masses were palpable. There was moderate rigidity of the right rectus muscle. The tenderness was worse on deep pressure. Rectal examination again gave negative results, and there was no blood on the gloved finger. Bowel sounds were normal. A blood count showed 13,200 white blood cells with 59 segmented forms and 41 lymphocytes, 4,610,000 red blood cells, and a hemoglobin estimation of 10.2 Gm. The urinalysis gave negative evidence.

A clinical diagnosis of recurrent intussusception was made. Inasmuch as the pain was only present for an hour and a half and since an ileocecal intussusception had been found 17 days previously, it was contemplated, therefore, that the recurrence might be in the same area. The radiologist was called, and within two hours of the onset of symptoms a barium enema with low pressure was performed, in the hope that if the intussusception had recurred at the same site, it could be reduced by hydrostatic pressure. Much to our surprise, the entire colon filled well, down to the ileocecal valve and it was declared normal by the radiologist. The terminal ileum did not fill. Following the evacuation of the barium

From the Surgical Service of Memorial Hospital, Hollywood.

enema, the child felt somewhat relieved and for a while appeared symptom-free. At this particular interval, we thought that perhaps the intussusception had reduced itself rapidly by the enema before the radiologist had a chance to observe it.

The child was taken to his room and given parenteral fluids and supportive measures. About two hours afterwards, the episode of pain recurred, but it was not as severe as it had been when the child was first seen in the emergency room. The pain continued, but the intervals between episodes were much more prolonged. A decision was made, however, to operate again, as it was considered that an ileoileal intussusception, which could not be detected by barium enema, could just as well be taking place.

The child was operated on under cyclopropane-ether anesthesia, and just as the anesthetist was getting ready to administer the anesthetic, he had a convulsion on the operating table, which was quickly controlled by sedation. The abdomen was explored through a right lower rectus incision, and on opening of the peritoneal cavity about 400 cc. of bloody fluid was readily removed by suction. An ileoileal intussusception was found taking place about 2 feet from the ileocecal valve. This time the intussusception could not be reduced, and a bowel resection was therefore undertaken with removal of about 2 feet of gangrenous ileum. The bowel continuity was restored by an end to end anastomosis. The patient received 500 cc. of blood during the operative procedure.

The pathologist's report this time was: "(1) Gangrenous intussusception, ileum; (2) acute enteritis; (3) histoplasmosis (?). The Peyer's patches were found to be involved with an acute hemorrhagic inflammation involving the patch and overlying mucosa. In the reticuloendothelial cells of the Peyer's patches there were masses of pale refractile bodies precisely resembling Histoplasma capsulatum." The organisms were subsequently identified by special staining with Schiff stain.

The postoperative course was stormy. Immediately postoperatively, convulsions developed, but gradually responded to sedation. The temperature went up to 103.3 F. rectally, the pulse rate was 160, respirations were 24, and the blood pressure was 190 systolic and 130 diastolic. Continuous nasal-gastric suction was maintained; nasal oxygen and parenteral fluids were administered. Various sedatives were tried including Luminal Sodium intramuscularly, and it was found the child could best be controlled by repeated small doses of Demerol. The vital signs gradually improved as well as the hypertension, and beginning on the third day following surgery, he was given 0.5 ounce of clear fluids by mouth every hour with the Gomco pump turned off. The usual measures of broad spectrum antibiotics were given prophylactically as well as blood, and parenteral fluids were given in appropriate amounts for a child of his age in order to maintain adequate blood volume and proper chemical balance. Once he began taking fluids by mouth, he gradually improved and was allowed out of bed as soon as his condition warranted it.

Histoplasmin skin tests as well as bone marrow studies for histoplasmosis, performed postoperatively, gave negative results. Once he was out of bed, the patient recovered quickly and was dismissed from the hospital on Feb. 21, 12 days following surgery.

It is now over nine months since the last operation, and the child has been symptom-free. When last seen in the office, he had completely recovered.

Discussion

Intussusception in a child at the age of six years is indeed a rare occurrence. A review of the literature reveals that the incidence of intussusception at this age is less than 2 per cent.[1-4] Gross[1] in his book on pediatric surgery reported a series of 702 cases of intussusception, in which nine of the patients were reported at the age of five to six years, and in none was the disease recurrent at that age. Santulli and Ferrer[2] reported 80 per cent of their patients were under one year of age.

The presence of H. capsulatum in the Peyer's patches raises an interesting point as to the possible etiology of the intussusception in this case. The organism was identified by the specific stain of Schiff; however, the skin tests and bone marrow studies by sternal puncture failed to show generalized histoplasmosis. Although the child had a gangrenous intussusception, it is noteworthy that no masses could be felt on physical examination of the abdomen, bowel sounds were normal, and there was no bloody mucus on rectal examination.

Whether the intussusception will again recur is problematic. The child is being carefully watched, and the father has been instructed to report any type of abdominal pain immediately to the physician.

Summary

A case of ileocolic intussusception recurring as an ileoileal intussusception in a six year old boy with histoplasmosis of the Peyer's patches of the ileum, treated successfully by surgery, is reported.

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Diabetes Screening in Polk County

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In the past five years there has been an increasing interest in multiphasic screening projects including as many as 12 tests.[1] These have been carried out predominantly in large cities or in isolated industrial areas. Studies have been run by health departments,[2] community[3] and general hospitals,[4] industrial health plans,[5] and individual physicians.[6] The purpose of this paper is to discuss the project in Polk County where a predominantly Negro and low income white population being tested for syphilis was also screened for diabetes.

The Polk County Health Department, with the cooperation of the Florida State Board of Health and the Polk County Medical Association, planned a countywide blood testing survey for syphilis. It was decided to draw an additional sample of blood on all patients over 30 years old to be screened for elevated blood glucose. This addition to the survey was intended to determine whether or not enough asymptomatic diabetes was present and whether or not response to referrals to private physicians was adequate to justify recommending this addition for other countywide blood surveys.

Preliminary to the survey, community programs were organized to which prominent Negroes as well as a few white public officials were invited. The purpose of the survey was explained, motion pictures on diabetes and syphilis were shown, and questions were answered. In addition to these programs, posters urging blood testing were placed in all areas to be tested. Radio and newspaper releases gave the reasons for the tests as well as the location of the blood testing stations. There were three teams, each consisting of a nurse and a clerk. Each station was manned by one of these teams and was equipped with a card table, chairs, and a sign indicating that blood specimens for testing would be taken there. A sound truck drove through each area playing records and making spot announcements urging people to have their blood tested and giving the locations of the blood testing stations, most of which were in front of popular business establishments. Blood specimens were taken from 4 to 8 p.m. on weekdays and from 10 a.m. to 5 p.m. on Saturdays. No attempt was made to have patients in a fasting state.

The blood specimens for diabetes screening were taken in Sheppard blood-taking tubes to which thymol and sodium fluoride had been added. The blood was obtained from the tubing of the serology tube so that only one venipuncture was necessary for both tests. The blood was tested at the Florida State Board of Health Laboratory in Jacksonville with the Clinitron, a mechanical laboratory apparatus which screens blood sugar at 130 mg. per hundred cubic centimeters of blood by the Wilkerson-Heftman method at the rate of 120 determinations an hour. A blood glucose determination by the Somogyi-Nelson method was made on all blood that screened positive.

All patients with elevated blood glucose were given appointments at one of the seven County Health Department offices. During the first part of the retesting, those who gave no history of having diabetes were merely checked with a fasting blood sugar, but those tested later were given 100 Gm. of dextrose in water by mouth and two hours later a second specimen for blood glucose determination was drawn.

All patients with previously diagnosed diabetes were referred back to their physician, and a record of their survey blood glucose level as well as a fasting blood glucose level was mailed to him. All persons without a previous history of diabetes who had a tentative diagnosis of diabetes made on the basis of retesting with a fasting blood sugar or modified glucose tolerance test were referred to their own physician, and a record of all blood glucose determinations was mailed to him. A follow-up was made about four months after the retesting was begun to determine whether or not persons with previously diagnosed diabetes as well as those with newly diagnosed diabetes had reported to their physician, whether they had returned to him regularly, and whether they were on a diet, taking insulin, or both.

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Results of Survey

The results of the blood testing for syphilis have been published elsewhere.[7] The survey was made from Sept. 8, 1955 to Oct. 16, 1955. As is seen in table 1, 2,670 persons were screened for diabetes, and 40 had blood glucose levels above 130 mg. per hundred cubic centimeters of blood. As noted in table 2, 15 of those with a positive reaction to the screening test were already known to have diabetes, but had not been under a physician's care recently. Of the 25 who were not known to have diabetes, 23 were retested. The other two could not be tested; one had moved to Georgia without leaving a forwarding address, and the other had died.* Of the 23 with no history of diabetes who were retested, in 13 the reaction remained positive.**

Table 1

Persons screened having blood glucose levels above 130 mg. per hundred cubic centimeters of blood	40
Persons screened having levels below 130 mg.	2,630
Total tested	2,670

Table 2

Known to have diabetes		15
Not known to have diabetes		25
Not retested	2	
Negative after retest	10	
Positive after retest	13	
Total screened positive		40

Criteria for Diagnosis on Retest

Although it had been planned to use a fasting blood sugar of 130 mg. per hundred cubic centimeters of blood or a blood sugar two hours after oral dextrose of 140 mg. as the upper limit of normal, there was no difficulty in the diagnosis of most cases as the blood sugar was much higher than this. As is seen in table 3, there were only two cases in which the fasting blood sugar was below 130 mg., but diabetes was considered to be present on the basis of a blood sugar above 140 mg. (157 and 174 mg.) two hours after oral dextrose.

The patient in one of these cases was the son of a nonsurvey diabetic person accidently discovered and previously mentioned. His private physician thought he did not have diabetes and that the elevated two hour glucose was caused by cirrhosis. The patient was requested to have a complete glucose tolerance test, but failed to do so. In the other case, diabetes was diagnosed by a private physician, and insulin therapy was instituted. Thus, of the 13 patients who satisfied our criteria for the presumptive diagnosis of diabetes on retest, in 12 the diagnosis was confirmed by their private physicians (table 4) and in one was challenged but not definitely refuted.

Follow-up Problems

There were many problems encountered in following up this survey. Because of the size of the county, there are seven Health Department offices. Although all patients to be retested were asked to come to one of two retesting sessions, the response was poor, and individual appointments had to be made in many cases. Even then, many patients did not keep their appointments, and much time was wasted waiting for them. Including travel time, as much as eight hours was spent retesting a single patient.

Many patients had not given addresses complete enough to permit the investigator to find them, and consequently a painstaking search was necessary to locate them. As was noted, the thoroughness of the investigator resulted in retesting all but two persons whose reaction was positive in the survey.

Four Month Follow-up

To evaluate whether or not the patients with known diabetes or with previously unknown diabetes had benefited from the survey, a follow-up was made about four months after the retesting was begun. All 27 patients (15 previously known diabetic patients and 12 physician-confirmed new diabetic patients) were contacted. Of those with previously undiagnosed diabetes, all 12 had reported to their private physicians or to the Diabetes Clinic at the Polk County Hospital. All but three of them had seen their physicians within the past month. Nine were on a diet and taking insulin, two were on diets but not taking insulin, and one was not on a diet nor taking insulin. The one patient on no diet and not taking insulin was, according to her physician, advised to be on a strict diet.

Of the 15 previously known diabetic patients, 10 had returned to their private physicians or to the County Hospital. One had contacted her physician by phone, but four had made no attempt to return to treatment. Six were on a diet and taking insulin; three were on a diet, but were not

*The patient died at the age of 47 of a cerebrovascular accident. Her routine urinalysis on admission to the hospital was negative for sugar, but no blood glucose determination was made.

**In addition, the mother of one of the patients presented her son's appointment card, was tested and was found to have previously undetected diabetes. She was not counted in the survey.

Table 3

Case	Age	Race	Sex	Survey Blood Glucose in Milligrams	Fasting Blood Glucose in Milligrams	Fasting Blood Glucose in Milligrams	Modified Glucose Tolerance Blood Glucose Two Hours After Dextrose in Milligrams	Diagnosis Confirmed by Private Physician
1	70	N	F	228		137	371	Yes
2	37	N	F	343	214			Yes
3	43	N	M	171		106	157	No
4	36	N	F	251	286	240	457	Yes
5	73	W	F	180		*		Yes
6	50	N	F	263		180	442	Yes
7	41	N	F	149		274	386	Yes
8	48	N	F	157		249	360	Yes
9	67	N	M	266		240	QNS	Yes
10	63	N	F	290	257			Yes
11	66	N	F	200	214			Yes
12	49	N	F	206	280			Yes
13	65	N	F	243		114	174	Yes

* Not retested in the Health Department. Diagnosed by a private internist after the survey, but before the patient could be retested.

taking insulin; one was taking insulin, but was not on a diet; and five were not on a diet nor taking insulin. It will be seen from this follow-up that those with newly diagnosed diabetes were cooperative in reporting to their physicians and in following his instructions regarding diet and insulin. Of the previously known diabetic patients, however, only two thirds returned to treatment. The return of 10 uncontrolled diabetic patients to medical care is certainly of significance, and they should be added to the 12 newly discovered diabetic patients in evaluating the accomplishments of the survey.

Table 4

Diagnosis of diabetes by private physican	12
Diagnosed not diabetes	1
Total Positive on retest	13

Summary

A countywide blood-screening program for diabetes was carried out on 2,670 adults. An intensive follow-up campaign resulted in 10 of 15 previously known diabetic patients and in all 12 of the newly discovered diabetic patients returning to their private physicians or to the County Hospital for diabetic management. Many problems encountered in following up a survey of this type are discussed.

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VOLUME XLIV
NUMBER 9

Hiccups as Sole Presenting Symptom Of Myocardial Infarction

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In 1939, Weiss[1] reported his observations in three cases of coronary artery occlusion complicated by hiccups. Swan and Simonson[2] confirmed the presence of this complication in myocardial infarction, and related their application of phrenic nerve crush as a therapeutic measure. Perchuk and Liveson[3] had similar experiences, two of their cases displaying gastrointestinal hemorrhage as well as hiccups. A perusal of the literature, however, reveals no reference to hiccups as the sole presenting symptom of coronary artery occlusion.

Report of Case

The patient was a 65 year old Negro man with a history of congestive heart failure which responded to digitalis and mercurials. He was first seen on June 14, 1956, for a complaint of hiccups which awoke him from sleep four days previously. He appeared exhausted and complained of pronounced weakness because of this siege. Only slight dyspnea and orthopnea were evident. The neck veins were distended 3 plus, and a positive liver reflux was present. The chest was clear bilaterally. The heart was enlarged to the left with the point of maximal impulse at the anterior axillary line in the fifth interspace. The pulse rate was 90, and the rhythm was sinus in character. A rough systolic murmur was heard at the apex, and P-2 was greater than A-2. The blood pressure was 90 systolic and 60 diastolic. The liver and spleen were not palpable. There was a 2 plus pitting edema of both lower extremities. He was given digoxin, Mercuhydrin, a salt-low diet, and 100 mg. rectal suppositories of Thorazine.

Five days later, on June 19, the hiccups were still present. An electrocardiogram was taken at this time because of the patient's previous history of congestive heart failure. The tracings disclosed the presence of an acute anterolateral myocardial infarction (fig. 1). The patient was treated with anticoagulants and 25 mg. doses of Thorazine intramuscularly upon his admission to the hospital. Laboratory studies revealed a nonprotein nitrogen of 45 mg. per hundred cubic centimeters; the Wassermann reaction was negative; urinalysis showed no sugar, a trace of albumin, occasional granular and hyaline casts, 2 to 6 white blood cells, and no red blood cells. The hemoglobin estimation was 8.99 Gm.; the red blood cell count was 3,690,000, and the white blood cell count was 8,800, with polymorphonuclear leukocytes 78 per cent and lymphocytes 22 per cent.

Eleven days after the onset of hiccups, there was no evident response to Thorazine or sedation. On June 21, the patient was given 5 mg. of prednisone every eight hours with gratifying improvement at the end of 24 hours, and almost complete abatement in the next 48 hours. The dose of the drug was gradually reduced within a period of 10 days, during which period the patient reported occasional short periods of hiccups, which ceased spontaneously within a few minutes after onset. On June 26, a repeat tracing disclosed the subacute phase of the previous infarction and, in addition, a decided accentuation of Q_2, which is probably indicative of the posterior progression of the infarcted area (fig. 2).

Discussion

Painless myocardial infarction has been noted by many observers, with a greater reported incidence in the Negro race. The occurrence of hiccups without obvious etiology, therefore, merits electrocardiographic investigation for coronary artery disease.

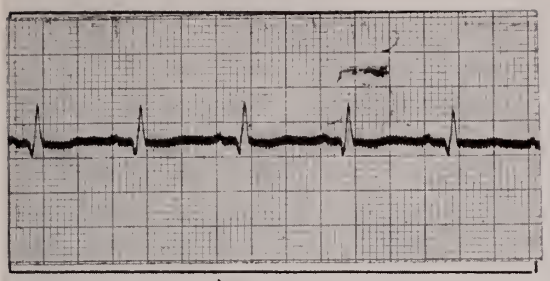
Diaphragmatic tic is probably due to a reflex mechanism in anterior infarction because of the close interconnection between the superficial and deep cardiac plexuses on the one hand, and the cervical segments of the spinal cord, the sympathetic ganglions, and the vagus on the other. When the under surface of the heart becomes infarcted, the mechanism of hiccup production is most likely one of direct phrenic nerve or diaphragmatic irritation. Figure 3 represents a tracing taken on June 26, in which Q waves were inscribed in the left infracostal region in the midclavicular and midaxillary lines. It is my opinion that this represents infarction on the diaphragmatic surface of the heart, and that hiccups occurred because of the localized inflammatory reaction and edema irritating the diaphragm and the rich underlying phrenic plexus.

The decision to administer prednisone in this instance to counter the hiccups was suggested by the work of Prinzmetal and Kennamer.[4] These authors were able to convert complete heart block associated with posterior myocardial infarction to sinus rhythm within 12 hours after the administration of ACTH. It was postulated that the corticotropin suppressed the inflammation and edema surrounding the auriculoventricular node and the bundle of His. In addition, the work of Hepper, Pruitt, Donald and Edwards[5] amply

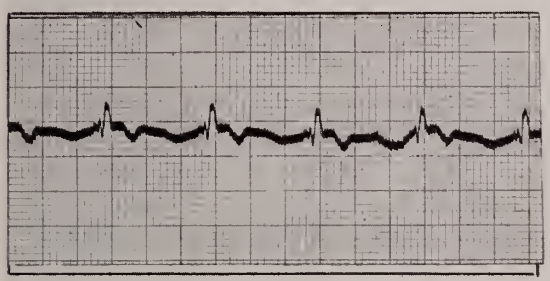
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Fig. 1.—Electrocardiographic tracing taken on June 19, 1956, which displays acute anterolateral infarction pattern.

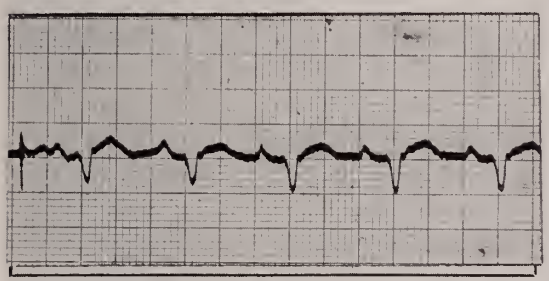
Lead I



Lead II



Lead III



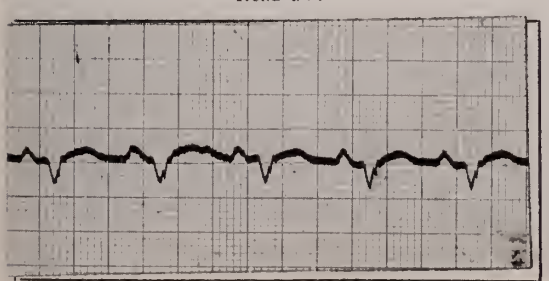
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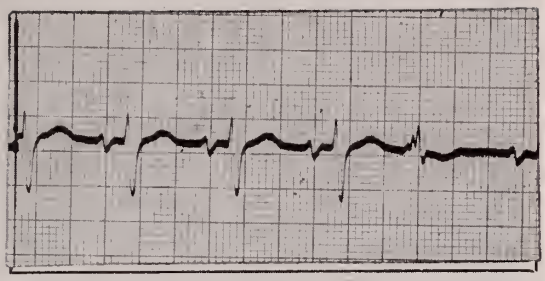
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Lead aVf



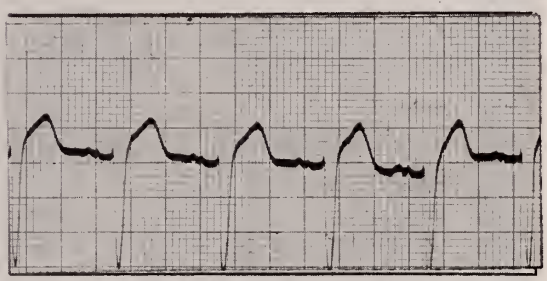
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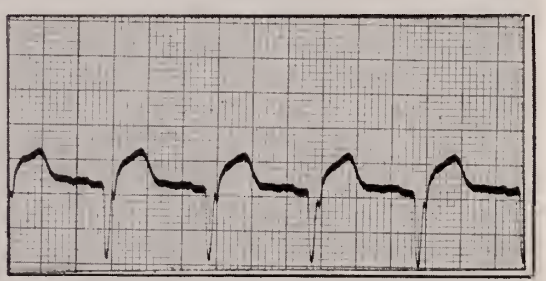
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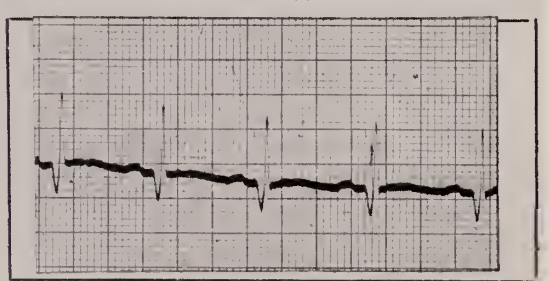
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Lead V4



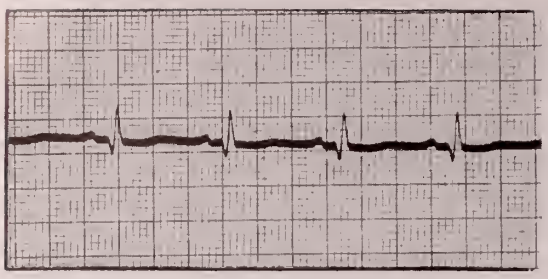
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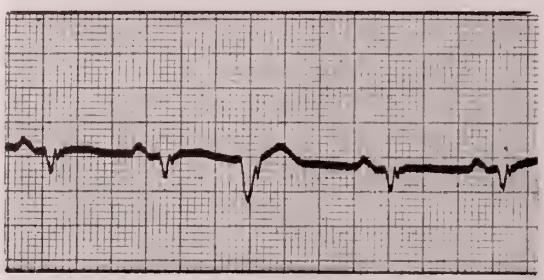
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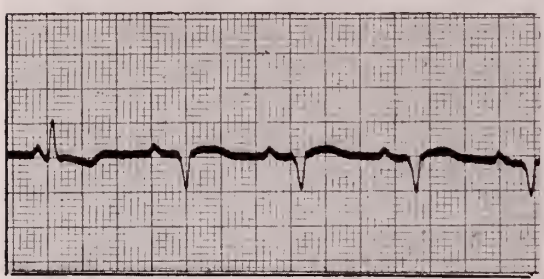
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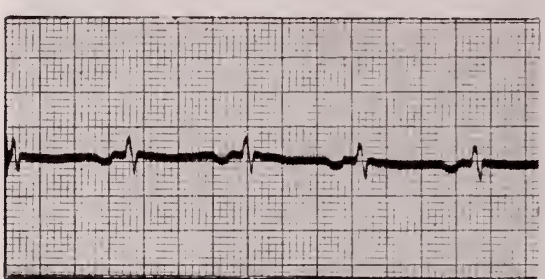
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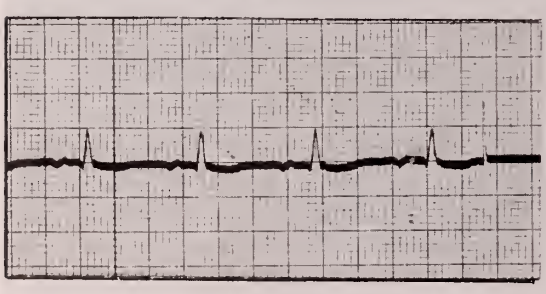
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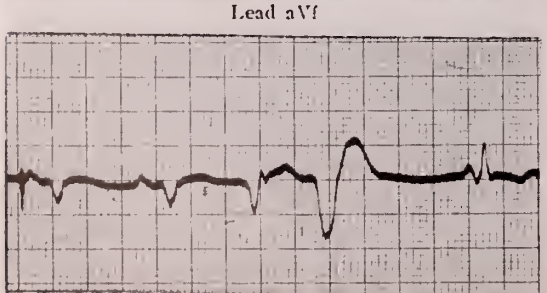
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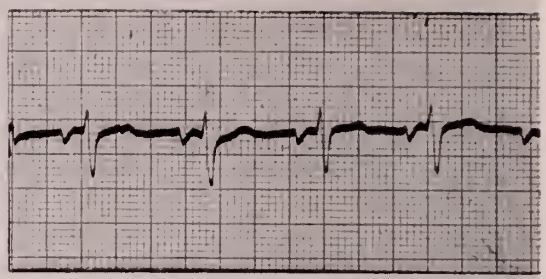
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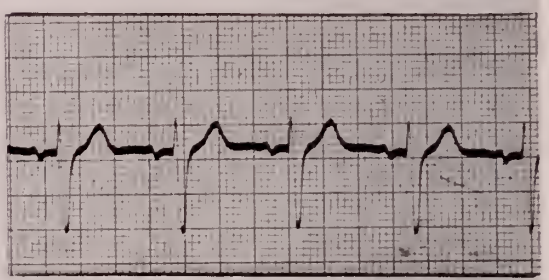
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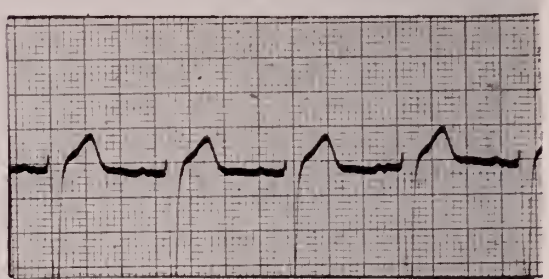
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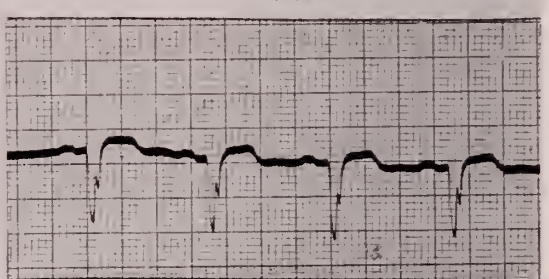
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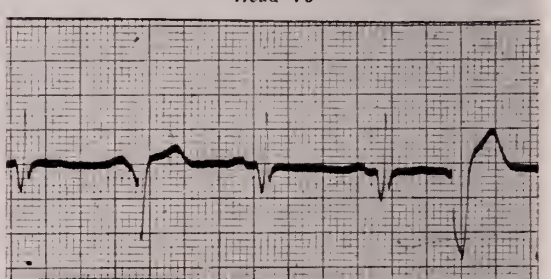
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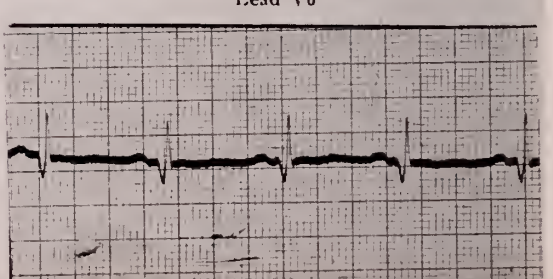
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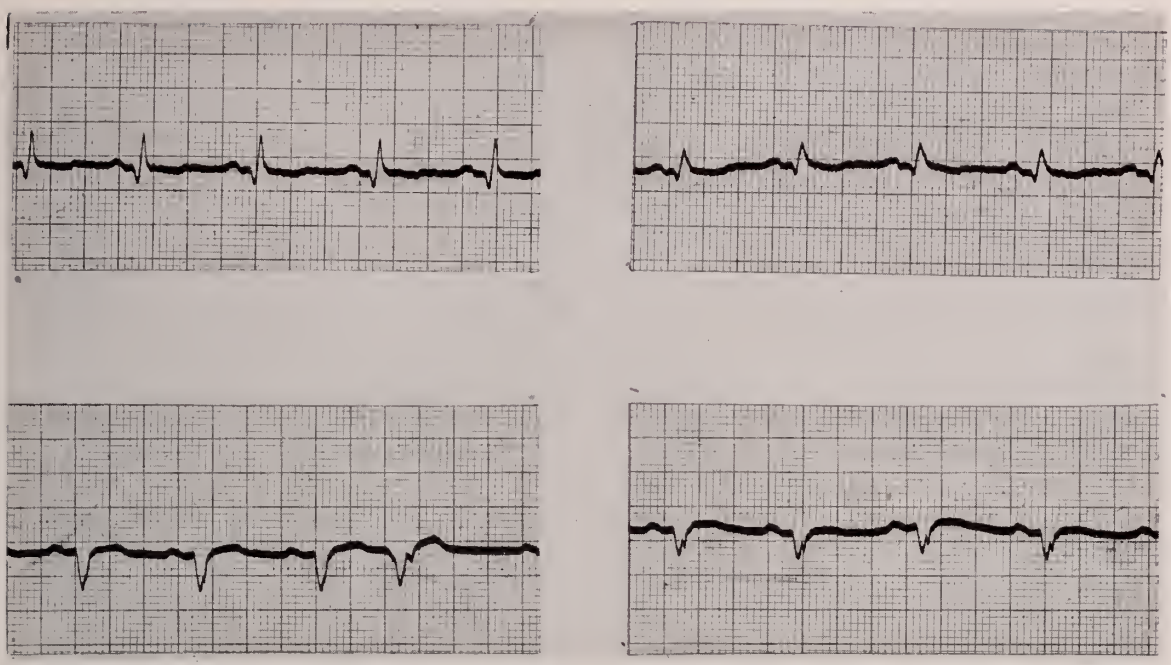


Fig. 3. — Lower left: Infracostal area in midclavicular line. Lower right: Infracostal area in anterior axilliary line. Q waves probably indicate infarction on diaphragmatic surface of the heart. Upper left: Represents lead V-8. Upper right: Is V lead at vertebral column.

attests to the safety of steroid administration in acute myocardial infarction. Cortisone was administered to dogs with experimentally produced coronary artery ligation. Although microscopically detected delays were noted in the four to six day old infarcts, there was no measurable difference in the healing of the infarcts at the end of 60 days between the cortisone treated animals and the controls.

Summary

A case is presented which displayed hiccups as the only presenting symptom of myocardial infarction.

Tracings taken over the left infracostal region in the midclavicular and midaxillary lines inscribed Q waves. This result may be indicative of infarction over the diaphragmatic surface of the heart.

Hiccups in myocardial infarction may occur by a reflex mechanism in anterior involvement, and by direct irritation of the diaphragm or phrenic nerve plexus in posterior infarcts involving the under surface of the heart.

Steroid therapy may be a valuable treatment adjunct in hiccups due to myocardial infarction with involvement of the diaphragmatic surface of the heart.

Opposite Page

Fig. 2. — Electrocardiographic tracing taken on June 26, 1956, which shows subacute phase of anterolateral infarction.

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The Risk of Ascaris Infestation From the Use of Human Sludge as Lawn Fertilizer

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The modern methods of handling the ancient problem of disposal of human waste stand at the apex of achievements in public health. The solution of this problem, however, has created a bothersome satellite of smaller problems relating to the presence of still infectious agents in the final products of the modern sewage disposal plant. It will be the purpose of this paper to report the results of a special study on one of these problems.

A recent report has shown that the modern sewage treatment process does not necessarily completely destroy all pathogenic organisms. Viruses of the Coxsackie group, tubercle bacilli and even typhoid bacilli can be detected in the effluent by suitable procedures.[1] In 1918, Dr. Homer Venters, a public health laboratory worker in Tampa, demonstrated ascaris ova in 44 per cent of 200 specimens of sludge from Imhoff Tanks.[2] During the second World War, Cram and his coworkers[3] surveyed the sludge from 16 municipalities and 17 army camps in the United States. No cysts or ova of parasites were found in the specimens from the municipalities, but one third of those from the army camps contained viable ascaris ova.

Keller and Hide,[4] two South African investigators, carefully defined the role of sewage sludge as a possible source of ascaris infestation when this sludge was used as fertilizer on municipal sewage farms. They demonstrated ascaris ova in the sludge from three separate disposal plants ranging from 749 to 7,805 ova per gram dry weight. The percentage of viable ova in each specimen examined ranged from 72.3 per cent in the raw sludge to 42 per cent in the sludge that had dried for 42 days. The extreme resistance to drying of ascaris ova was demonstrated by the presence of viable ova in a sample which contained only 5 per cent moisture after drying an unknown length of time. The sewage treatment process had remarkably little effect on either the total numbers of ascaris ova per gram dry weight of sludge, or their viability. They concluded that heat treatment is necessary to convert sewage sludge into a safe fertilizing material.

As is well known, heat-treated sewage sludge has been used extensively in commerical fertilizer in the United States. The growth of small urban and subdivision sewage disposal plants in Florida, however, has led to the use of plain dried sludge for lawn and garden fertilizer, often primarily as an aid to the disposal plants in ridding them of their accumulated sludge.

The municipal sewage disposal plant in Tampa contracts this sludge to a local nurseryman, who in turn retails it as lawn fertilizer. During the summer this arrangement was initiated, however, a local pediatrician, Dr. Lewis T. Corum, treated a child with severe ascariasis and, in a careful history, obtained the interesting information that the child had had contact with sludge obtained from this source and used on the family lawn as fertilizer. This paper is a report on the subsequent investigation to determine whether this sludge was a source of ascaris infestation in this community.

Description of Investigation

Specimens of sludge were obtained at approximately biweekly intervals from the Tampa Municipal Sewage Disposal Plant. This is a primary sewage treatment plant in which sludge is removed from the settling basins, allowed to digest at 80 to 90 F. for approximately 30 days and distributed to beds for drying up to 21 days. After determination of moisture content, the specimens were examined for ascaris ova by the standard zinc flotation method and by quantitative Stoll counts. These examinations were made by the Disposal Plant Laboratory (for moisture) and the Tampa Branch of the Florida State Board of Health Laboratory (for ascaris ova counts). Three specimens each were taken from the raw, the digested, and the drying sludge. This dried sludge was the only source of plain commercial sludge for lawn fertilizer in Tampa at that time. No special viability cultures were made, but estimates of viable eggs were made by visual inspection of the ova from each specimen examined.

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The second major part of the investigation was to determine whether or not the children exposed to the sludge, used as lawn fertilizer, were actually infected by the ova known to be present. Two groups of children, who were alike in all respects except exposure to sludge as lawn fertilizer, were studied for prevalence of ascaris infestation. Names of households using sludge as fertilizer were obtained from the retail dealer. Control households were selected from the City Directory. All interviews and examinations were carried out without knowledge as to the identity of the child in either the sludge or control group. The stool specimens submitted by children under age 15 were examined for parasitic ova by the standard zinc flotation method.

Results of Study

Table 1 gives the results of the examinations of sludge for ascaris ova. Under the columns headed "Ascaris Ova/ml" the "O" indicates no ova were present on either zinc flotation or quantitative Stoll counts. Less than 100 per milliliter was reported when ova were present on zinc flotation, but insufficient to appear on the Stoll count. Over 100 per milliliter was given as the actual Stoll count. It is seen that ova were present in at least one of the three specimens of dried sludge submitted on each date shown, and 400 per milliliter was the maximum found. Visual inspection indicated that from 10 to 50 per cent of the ova were viable.

Table 1.—Ascaris Ova and Moisture Content of Sludge, Tampa Municipal Sewage Disposal Plant November 1955 - January 1956

Date of Examination	Type of Sludge: Raw		Digested		Drying	
	Per Cent Moisture	Ascaris Ova/ml	Per Cent Moisture	Ascaris Ova/ml	Per Cent Moisture	Ascaris Ova/ml
11/9/55	94.5	0	91.3	-100	56.3	-100
	94.5	0	91.3	100	56.3	300
	94.5	0	91.3	-100	56.3	400
11/28/55	95.1	0	92.3	0	36.7	0
	95.1	0	92.3	0	36.7	-100
	95.1	0	92.3	-100	36.7	0
12/14/55	94.9	0	92.1	0	36.7	0
	94.9	-100	92.1	0	36.7	0
	94.9	0	92.1	-100	36.7	-100
1/12/56	94.6	0	37.3	-100	34.1	-100
	94.6	0	37.3	-100	34.1	100
	94.6	0	37.3	0	34.1	0
1/27/56	95.3	-100	92.4	-100	43.3	-100
	95.3	0	92.4	-100	43.3	-100
	95.3	0	92.4	-100	43.3	-100

-100 denotes that ova were present on gross zinc flotation, but in insufficient numbers to permit counting by the Stoll count method.

Table 2.—Completed and Incompleted Investigations in a Survey of Tampa Households for Intestinal Parasites

	Sludge Group No.	%	Control Group No.	%	Total No.	%
Initial households	154	100	168*	100	322	100
Completed investigations	110	71.4	95	56.5	205	63.6
Incomplete investigations	44	28.6	73	43.5	117	36.4
Reasons For Incomplete Investigations						
Total	44	100	73	100	117	100
Not home	23	52.3	38	52.1	61	52.1
No such address	2	4.5	25	34.2	27	23.1
No children	18	40.9	6	8.2	24	20.5
Not interested	1	2.3	3	4.1	4	3.4
Unknown	0	0	1	1.4	1	0.8

* Includes 14 added addresses to original control list.

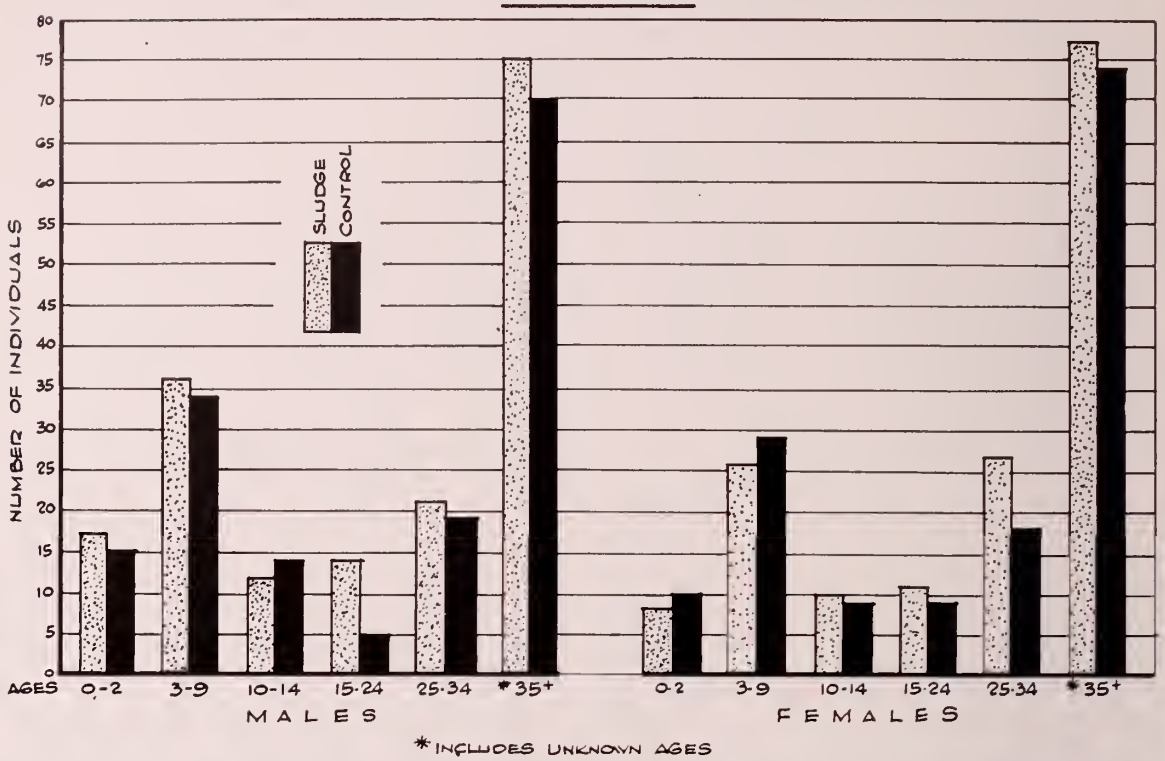
The fact that a smaller number or no ova were found in the digested and raw sludge was interpreted as being due to the high moisture content which would operate as a dilution factor. This same observation was made in a similar study in South Africa.[1] Uneven distribution of the ova in the raw sludge would also increase the probability of obtaining repeated negative samples.

Information was obtained on the interview investigation form to determine whether the two groups examined were reasonably similar in all respects except exposure to sludge. Table 2 shows the percentage of completed investigations made on the original households, and the reasons for incomplete investigation. It is noted that 71.4 per cent of the sludge households had completed investigations compared with 56.5 per cent of the controls, and the reason for the fewer completions in the latter was the large number with no such addresses. It is also noted that there were more families with incomplete investigations in the sludge group because of the fact that there were no children. This is probably so since the sludge households had a large number of older retired couples who had the time and money necessary to take extra care of their lawns. Households without children were not pressed for completion of the interview questionnaire.

Figure 1 shows the comparability of the occupants of the households with completed investigation forms by age and sex. The grouping for age of the children was made to fit the ages we considered to be the natural periods when ascaris might or might not be acquired. Unknown ages were included in the 35 plus group. The occurrence of selected characteristics within the two groups, which might influence the prevalence of

FIGURE-I

OCCUPANTS OF SLUDGE & CONTROL HOUSEHOLDS BY AGE & SEX



parasites, was studied. There was no significant difference in the occurrence of young children, septic tank sewage disposal, poor storm drainage, city water supply, or prior parasites in the family between the two groups. Neither sludge nor control children gave a history of having had or been treated for ascaris within the six month period prior to interview. This extended over the period of time when they were exposed to the sludge and could have become infected and treated prior to the survey.

Of the 109 children in the sludge households interviewed, 33.0 per cent did not submit stool specimens for examination. Of the 113 children in the control group, 28.4 per cent were not examined. It was concluded that these unexamined children would not have changed the final results had they been examined, since they were essentially alike in as many characteristics as we could examine from the survey interview questionnaire.

Table 3 gives the results of the laboratory examinations on the stool specimens submitted. The total number of children in the sludge-exposed group was 109, and in the control group 113. Of the 109, 73 or 67.0 per cent submitted specimens for examination, and one positive ascaris stool was found. Of the 113 control children, 81 or 71.6 per cent submitted specimens for examination, and no ascaris ova were found. The one positive ascaris stool was from a two year old white male child. This single positive has no statistical, and we believe no actual, significance in demonstrating a difference in risk of ascaris infection between the two groups of children.

Table 3.—Results of Laboratory Examinations for Intestinal Parasites, Tampa Survey, 1955

	Sludge Group	Control Group	Total
Total children in investigated homes	109	113	222
Number children submitting specimens	73	81	154
Laboratory findings:			
No parasites	67	67	134
Ascaris	1	0	1
Hookworm	0	2	2
Pinworm	4	8	12
Other (E. coli, E. nana, Giardia)	1	4	5

Discussion

It is believed that the results of the investigation show that whereas viable ascaris ova were present in the sludge sold as lawn fertilizer in Tampa, it did not produce a significant risk of infection to the children so exposed. It is thought that no obvious bias was present to alter the

comparability of the two groups of children whose stools were examined for the parasites. There is the possibility of false negative laboratory tests on a single stool from an infected child, but this possibility should be equally distributed between the two groups. The combined total of all parasitic ova found in the two groups indicated a slightly higher experience with parasites in the control as compared with the sludge group. The combined parasitic index of 12.9 per cent for the total 154 children is approximately that expected from previous experience in school surveys of similar populations, and is evidence against any significant number of false negative examinations.

Collateral evidence that the low prevalence of ascaris found in this survey is accurate was obtained by a brief survey of the sludge from three subdivision sewage disposal plants in this area. Out of a total of 21 specimens examined, over a two month period, only four gave positive evidence of ascaris ova, and only one viable egg was seen in each of the four positive specimens.

Since from 1 to 2 cubic yards of sludge were spread on the lawns, assuming 100 ova per milliliter, approximately 7,650,000 ova were added to each lawn of which 10 to 50 per cent were viable. This estimate would compare with from 350,000 to 1,000,000 ova deposited each day from a moderately infected child. Apparently either the ova are rapidly inactivated by sunlight, as suggested by the South African investigators, or the habits of these particular children are not such that would lead to excessive ingestion of contaminated dirt. It is also possible that a single or very few viable ova were ingested. Due to the fairly short stay of individual ascaris worms in human hosts (ascaris is often called "the unhappy parasite"), they may have been acquired and shed prior to the time of the survey.

These observations, plus the usual absence of serious illness in all but the most severe ascaris infestation, should eliminate any undue alarm over sludge used as lawn fertilizer being a real public health hazard. The fact, however, that it presents a potential risk of ascaris transmission cannot be denied. Heat sterilization, before retail distribution, may do much to relieve public apprehension, and would insure that even this negligible risk to the public is eliminated. Temperatures of 65 C. are reported as lethal for ascaris ova after contact for three minutes, and these would presumably be the minimum requirements for such sterilization.

Conclusion and Summary

Viable ascaris ova in the range of 100 per milliliter were shown to be present in sewage sludge sold as lawn fertilizer in Tampa.

An epidemiologic survey demonstrated that there was no significant difference in the prevalence of ascaris in a group of children exposed to this sludge as compared with a group of control children living one block away from their respective homes. The sewage sludge used as lawn fertilizer was shown to be a potential but not an actual source of ascaris infestation in this community.

Heat sterilization of the sludge for a minimum of three minutes at 65 C. would eliminate this potential hazard.

Appreciation is expressed to an entire team of public health workers without whose assistance this study would not have been possible. A total of 25 persons was involved directly in carrying out the study. They include Drs. Frank V. Chappell and Clack D. Hopkins and staff of the Hillsborough County Health Department, Dr. Lorenzo L. Parks and staff, Mr. H. D. Venters and staff, Dr. Albert V. Hardy and staff and Mr. David B. Lee and staff, all of the Florida State Board of Health; and Mr. C. M. Courson and staff of the Tampa Municipal Sewage Disposal Plant.

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Improved Results in the Postcoital Test With Terramycin Vaginal Suppositories

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The postcoital examination of the cervical mucus should be a part of every routine investigation of the sterile couple. It is the only means by which the actual penetration of the sperm into the cervical canal can be established.

Previous investigators[1-3] have shown that the cervical mucus undergoes cyclic changes and that there is an optimal time for sperm penetration through the mucus. Variations in the appearance of the mucus are not uncommon, and moderate viscosity with a reduced volume is not incompatible with pregnancy, although a high fertility index is usually associated with the production of abundant, clear, acellular, low viscosity mucus. The appearance of the mucus in infertile women may be the same as that of fertile women. Furthermore, even severe abnormalities and functional disturbances such as tubal closure or cystic ovaries need not be reflected in disturbances of cervical secretion. Again, one may find the mucus to be scanty, viscous and cellular, or moderately profuse but cloudy, with leukocytes on microscopic examination, in subfertile or sterile women. The mucus may have the consistency of a thick jelly. This type of mucus never protrudes into the vagina and may be difficult to aspirate. In some women, only a small quantity of mucus is present at any time of the cycle, or the cervix may contain the mucopurulent type of mucus associated with endocervicitis.

This paper attempts to show that with the use of Terramycin vaginal suppositories there has been an improvement in the cervical mucus and a resultant improved postcoital test. From Aug. 1, 1952, to January 1954, the plain Terramycin vaginal suppository was used. Since January 1954 an improved tablet, Terramycin with polymixin, has been used. This preparation has lessened the number of complicating fungus infections that have occurred.

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Terramycin Vaginal Suppositories used in this study were provided by Chas. Pfizer & Co. through the courtesy of Dr. M. William Amster.

Material and Method

A total of 320 infertile couples were seen in private practice from Aug. 1, 1952, to Dec. 31, 1955. These couples were investigated with complete infertility studies which included history and physical examination of both partners, semen analysis, tubal insufflation and/or hysterosalpingogram, endometrial biopsy, postcoital examination and examination of the cervical mucus relative to Spinnbarkeit, arborization and retractility. A total of 457 postcoital examinations was performed on 134 patients who required treatment in an attempt to improve the test. Fifty-two patients were treated with the plain Terramycin vaginal suppository, and 82 patients were treated with Terramycin with polymixin vaginal suppositories.

Patients Treated with Terramycin Vaginal Suppositories.
from 8/1/52-12/31/55

No. of Patients	No. of Treated Patients	No. of P-C Tests	Pts. Treated with Terramycin (Plain)	Pts. Treated with Terramycin with Polymyxin
320	134	457	52	82

Table 1

From Aug. 1, 1952, to Dec. 31, 1954, 122 patients were studied for infertility. Seventy patients (57 per cent) had a good postcoital test and did not require treatment. Fifty-two patients were treated in this group to improve the postcoital test with Terramycin vaginal suppositories. They had a total of 146 postcoital examinations. There were nine patients (17 per cent) in whom itching and burning in the vagina with vaginal discharge developed. Vaginal smears revealed the presence of either trichomoniasis or moniliasis. All were relieved by stopping the treatment, by cool cornstarch baths, and by vinegar douches.

The postcoital tests were planned for the optimal time based on Spinnbarkeit examinations,

Patients Treated with Terramycin Vaginal Suppositories
from 8/1/52 - 12/31/53

No. of Patients	No. of Treated Patients	No. of P-C Tests	No. of Reactions	%
122	52	146	9	17%

Table 2

basal body temperature charts and the menstrual history. All 52 patients at the time of the first postcoital examination had numerous leukocytes in the mucus, no sperm, or an occasional dead or sluggish spermatozoon per high power field. Many of the other characteristics of poor mucus were also present such as scantiness, high viscosity, and thick jelly-like material. Many of the patients had no obvious cervicitis or endocervicitis, while others had varying degrees of cervicitis.

From Jan. 1, 1954, to Dec. 31, 1955, 198 patients were studied as previously described for infertility. One hundred and sixteen patients had good postcoital tests, while 82 patients had poor tests and required therapy. In this group of treated patients, Terramycin with polymixin vaginal suppositories were used. This tablet was an improvement over the plain Terramycin vaginal suppository in that there were fewer reactions. Nine patients (11 per cent) had itching, burning, vaginal discharge and vulvar rash. Relief from symptoms was obtained, on ceasing therapy, by cool cornstarch baths and vinegar douches. A total of 311 postcoital tests were made in this group.

Patients Treated with Terramycin with Polymyxin Vaginal Suppositories
from 1/1/54 - 12/31/55

No. of Patients	No. of Treated Patients	No. of P-C Tests	No. of Reactions	%
198	82	311	9	11%

Table 3

The postcoital tests were performed two to 24 hours after intercourse; the most frequent time interval was from four to seven hours after coitus. These were planned by basing the probable ovulatory period with the use of basal body temperature charts, Spinnbarkeit examinations, and retractility tests of the cervical mucus.

The specimens of the cervical mucus were collected with a Knight nasal biopsy forceps. This particular clamp was used because of its ease in reaching the level of the internal os and its concave tip in which the mucus would collect. Specimens of the mucus were collected at the level of the external os and the internal os, and were immediately studied microscopically for spermatozoa.

All patients received Terramycin (100 mg.) vaginal suppositories and were instructed to insert one tablet vaginally each morning for 10 days high in the vaginal canal. They were told not to douche. The postcoital test was repeated the following month. It was necessary to repeat the treatment more than once in a number of patients.

Cervical Mucus

The cervical mucus was considered improved after therapy if it was clear, abundant, contained few or no leukocytes under microscopic examination, and had a high Spinnbarkeit ratio. It was considered not improved if it remained cellular, thick, and scanty.

Sperm Migration

It is difficult to classify numerically a good or poor postcoital test in this series, since the husband's sperm count is an important factor. Obviously, if a semen analysis revealed a sperm count of 150 million per cubic centimeter with 90 per cent motility at one hour, we would find more spermatozoa per high power field in the postcoital test as compared to a sperm count of 30 million per cubic centimeter with 60 per cent to 70 per cent motility at one hour. These patients were not selective, but seen consecutively with varying sperm counts from 20 million to 250 million per cubic centimeter. In general, a good postcoital test was so termed if there were at least five to 10 active motile sperm per high power field. Sperm migration was classified as poor if none were found or an occasional mildly active sperm was seen per high power field. In many instances there were between 50 and 100 sperm per high power field with excellent motility, while in others between 2 and 5 sperm per high power field with good motility were present.

Results

The results in the series of patients (122) seen from Aug. 1, 1952, to Dec. 31, 1953, have been analyzed, since enough time has elapsed for eval-

uation. Seventy patients (57 per cent) had a good postcoital examination and did not require any therapy to improve the test.

Results with Terramycin Vaginal Suppositories
from 8/1/52-12/31/53

No. of Patients	Patients Not Requiring Therapy	Patients Requiring Therapy	Improved	%	Not Improved	%
122	70	52	34	65%	18	35%

Table 4

Fifty-two patients (43 per cent) had poor postcoital examinations and required treatment. Improvement was noted in 34 patients (65 per cent), and 18 patients did not improve.

Number of Pregnancies.
122 Patients
from 8/1/52-12/31/53

No. of Patients	No. of Patients Pregnant	%	No. of Improved P-C Tests	No. of Patients Pregnant	%
122	54	44%	34	17	50%
	60 Pregnancies 6 Miscarriages 3 Not yet delivered		No. of Non-improved P-C Tests	No. of Patients Pregnant	%
			18	4	22%

Table 5

Fifty-four patients (44 per cent) of the 122 patients studied and treated became pregnant.

Eighteen patients did not have improved postcoital tests after therapy. Four patients became pregnant (22 per cent). Of the 34 patients who had improved postcoital tests, 17 patients (50 per cent) became pregnant. Case 1 is an illustration.

Case 1.—The patient was a 38 year old nullipara with seven years of sterility. Her husband, by a previous marriage, had three children and was 50 years of age. His semen analysis was 49 million per cubic centimeter with 50 per cent motility at two and one-half hours and good progression. Tubal insufflation revealed patent tubes; endometrial biopsy showed secretory endometrium. On Sept. 13, 1952, a postcoital test on day 14 after two and one-half hours revealed at the level of the external os an occasional dead sperm per high power field with numerous leukocytes and scanty mucus. At the level of the internal os there were no sperm per high power field and the same condition of the mucus. She was given Terramycin vaginal suppositories for 10 days. The postcoital test was repeated on October 17 on day 15 of the cycle and showed the same picture as had previously been seen.

Again she was given another course with Terramycin vaginal suppositories. On November 14, a postcoital test on day 15 after four and one-half hours showed 10 to 15 sperm per high power field with very few leukocytes at the level of the external os and at the level of the internal os 25 to 50 sperm per high power field with excellent motility and no leukocytes. The postcoital test was once more repeated on December 10 (no therapy had been given prior to this examination) on day 13 after six and one-half hours. At the level of the external os there were between 10 and 15 motile sperm per high power field and at the level of the internal os between five and 10 motile sperm per high power field. The mucus was clear and acellular. The reaction to the Aschheim-Zondek test on Feb. 24, 1953, was positive, and the patient delivered a 7 pound 8.5 ounce male on October 12.

Fourteen of the husbands in this series had sperm counts under 40 million per cubic centimeter. Five of the wives became pregnant. An example is the following case.

Case 2.—The patient was a 25 year old nullipara with duration of infertility of four and one-half years. Her husband, aged 27, had a sperm count of 30 million per cubic centimeter with 66 per cent normal forms, 70 per cent motility at three hours, and good progression. Tubal insufflation showed patency; endometrial biopsy revealed secretory endometrium. A postcoital test on May 8, 1953, on day 13 after six and one-half hours showed the mucus to be thick, viscous and cloudy, and it contained numerous leukocytes. No sperm were seen at the level of the external os and internal os. The patient was given Terramycin vaginal suppository therapy.

The postcoital test was repeated on August 3 on day 11 after four hours and again the specimen showed no sperm, a moderate number of leukocytes, and mucus still somewhat scanty and slighty cloudy. She was given another course of Terramycin vaginal suppositories, and the postcoital test on November 19 on day 13 after five hours showed 25 to 50 sperm per high power field at the level of the external os and 10 to 15 sperm per high power field at the level of the internal os with good motility. The mucus was clear and abundant, and contained practically no leukocytes. Her last menstrual period was March 30, 1954, and there was a positive reaction to the Aschheim-Zondek test on May 23. She delivered a healthy normal male weighing 8 pounds and 15 ounces on Jan. 19, 1955.

Comment

The postcoital test is regarded as a means of determining the compatability between sperm and cervical mucus. Conception requires the cooperation of various factors. Improving the postcoital test is merely one of these factors. It must be emphasized that the patients in this series received other types of therapy in addition to the Terramycin vaginal suppositories to help bring about conception.

Terramycin vaginal suppositories were used until January 1954. The plain Terramycin vaginal suppositories were discontinued and replaced by an improved tablet, Terramycin with polymixin. This tablet reduced the incidence of local reactions and the recurrence of fungus infections.

Conclusion

Sixty-five per cent of the patients in the series here presented showed improvement in the post-

coital examination following Terramycin vaginal suppository therapy.

Seventeen per cent had complications of vaginal discharge, itching and vulvar rash with Terramycin vaginal suppositories. Only 11 per cent had the aforementioned complications using Terramycin with polymixin vaginal suppositories.

The pregnancy ratio is much higher in those patients with a good postcoital examination as compared to patients with a poor postcoital test.

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ABSTRACTS

The Surgical Treatment of Exophthalmic Ophthalmoplegia. By W. J. Knauer, Jr., M.D. Am. J. Ophth. 43:58-66 (Jan.) 1957.

The purpose of this paper is to describe the treatment of exophthalmic ophthalmoplegia by means of a modified technic of lateral orbital decompression and to discuss some of the indications for performing this relatively benign procedure. Illustrative cases are described in which this operation was performed seven times on five patients at the Wilmer Ophthalmological Institute. There was an average decrease in exophthalmos of 7 mm. in these cases; the maximum recession obtained was 11 mm. and the minimum, 4 mm.

In summary, the author observes that exophthalmic ophthalmoplegia is a syndrome, the exact pathogenesis of which is unknown. It can produce proptosis, ocular palsies, diminished or complete loss of vision, and, in severe cases, loss of the globe. It has been shown that adequate orbital decompression can be obtained either via the lateral or transcranial approach, although the latter is the more formidable. In many cases of this type, the general policy of watchful waiting has resulted in a number of ocular cripples and lost eyes. Late orbital decompression results in cosmetic improvement only and has no effect on the extraocular muscle palsies. There is experimental and clinical evidence which suggests that the changes in the extraocular muscles may be in part secondarily induced by the increased orbital pressure or exophthalmos.

Assuming that an adequate trial of medical treatment has failed, it is suggested that patients with exophthalmic ophthalmoplegia in whom there develop signs of extraocular muscle palsies or evidence of visual impairment undergo a decompression, preferably through the less formidable but adequate lateral approach.

Gastrointestinal Wheat Allergy; Two Recent Experiences. By H. J. Roberts, M.D. J. Allergy 27:523-530 (Nov.) 1956.

This report is presented primarily as a clinical and therapeutic study in view of the renewed interest in wheat allergy, particularly as this phenomenon relates to the sprue and celiac syndromes. It was prompted by the recent observation of two patients who demonstrated profound improvement of severe gastrointestinal disability only after a wheat-free diet had been instituted.

After reviewing the issues of gastrointestinal and wheat allergy as they pertain to the recent literature, the author reports the two cases in which the patients experienced prompt remission of symptoms on wheat-free diets. In the first case, severe primary sprue had been present which had become refractory to vitamin B_{12}, folic acid, and cortisone acetate. After the institution of this dietary regimen, the patient remained symptom-free. Both the hypocalcemia and steatorrhea reverted to normal one month after the diet was started. The temporary beneficial effects of steroid therapy previously noted in sprue may be ascribed to the interference with this hypersensitivity state.

The patient in the second case exhibited a severe gastrointestinal allergy to wheat manifested by diarrhea, a pronounced eosinophilia, and abdominal pain. A complete clinical and hematologic remission was also experienced in this case on a wheat-free diet, even though he was exposed to wheat flour dust during the course of his occupation as a baker. A specific sensitization to gluten or another of the products of wheat digestion is inferred.

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Timely Telephone Topics

Man's, and especially the physician's, adaptation to the telephone has resulted in the development of innumerable, and occasionally, diverse technics designed toward management of this necessary, but oftentimes inconvenient, mode of communication. None of these technics is perfect. Indeed, it is apparent that none can possibly be devised which might be considered even a close approximation to perfection. The auditory electronic connection between an ill and anxious patient with all his multiform ambivalent feelings and a physician who may have the internist's empathy, the surgeon's imperturbability or the psychiatrist's equanimity has all of the component parts necessary to produce reactions all the way from mutual gratification to explosive rejection.

Practically all physicians have found it necessary to establish a buffer in the form of a receptionist between themselves and the world outside their offices. Some even double this buffer system through the additional aid of their office nurse. The efficiency of these systems is usually in direct proportion to the adaptability of the personalities of the component members. While most often effective, these arrangements can, at times, result in patient dissatisfaction.

Surprisingly enough, a number of physicians find that their most time-consuming and troublesome calls come from members of their own profession. With the exception of psychiatrists, practically all doctors immediately recognize and respond to calls from fellow physicians. By the very nature of our profession we, of necessity, have become masters of "verbal diuresis." We cannot seem to subdue the native instinct to communicate to others all of the knowledge at our command concerning any subject from gout to the best method of recovering from the left-handed sand trap on number sixteen. Little do we realize how much of an advantage we have over our unhappy victim who usually has a sensitive patient at his deskside and cannot properly ventilate his feelings regarding the increase in dues at the country club.

There are a number of corrective measures which can be taken in an attempt to regulate this little plastic-encased, expensive, expressive, jangling, provoking, irritating, loving, tender, quarrel-

some, pretty, means and/or happy product of science. First, and foremost, we physicians have to set the example, so to speak, by being precise and to the point in our telephone conversations with others — especially with other physicians during office hours. Secondly, the buffer receptionists and nurses can be further utilized to screen unnecessary calls. Lastly, but certainly not the least importantly, education of the general public must be carried on. Along this latter line, we can continue to use the time-honored methods of receptionist instructions to callers supplemented by our own occasional chastisement of the lambs who insist on talking to the "GREAT PHYSICIAN" for the most important scheduling of an appointment for a check on his or her most "HORRIBLE" blood pressure. Additional avenues of instruction could easily be sponsored by the medical societies through articles in local newspapers. On a national level it does not appear amiss to ask our pharmaceutical friends to help us educate the public on telephone courtesy through use of short blocked-off notes or even discussion paragraphs along with their lay magazine advertisements.

As the old, old saying still is expressed—physicians come and go, but the telephone is here to stay. While we are still around, please let us really try to make our marriage to it last.

Scientific Program Planned for Annual Meeting Bal Harbour, May 10-14, 1958

The Eighty-Fourth Annual Meeting of the Florida Medical Association will take place in a new setting this year, the Hotel Americana at Bal Harbour, just north of Miami Beach. It is scheduled for May 10 to 14, with Saturday, May 10, and the morning and evening of Sunday, May 11, reserved for meetings of specialty groups. The first session of the House of Delegates convenes on Sunday afternoon, and in accordance with a ruling of the Board of Governors, no other meetings are to be scheduled at that time.

The arrangements in general follow the schedule carried out at the convention in Hollywood last year. The innovation at that time of scheduling two scientific assemblies only, and both on Tuesday, will be repeated this year. This plan gives members who can attend on but one day the opportunity to be present for the scientific assemblies and to enjoy the chief social events, scheduled for Tuesday night.

The First Scientific Session, with Dr. George T. Harrell Jr. presiding, will open at 9:30 a.m. on Tuesday and continue until 12:30. Three medical papers will be presented in the following order: "Hearing Loss in Persons of Advanced Age" by Dr. Abraham R. Hollender and Dr. Otto S. Blum of Miami Beach; "An Analysis of the Causes of Blindness in Florida" by Dr. Nathan S. Rubin of Pensacola; and "False Positive Pregnancy Tests Caused by Sparine and Thorazine" by Dr. Gerard H. Hilbert of Pensacola. After recess, the remainder of the morning session will be devoted to a panel covering recent advances in modern methods of diagnosis and therapy, with Dr. Richard Reeser Jr., of St. Petersburg, presiding. Dr. David Hume, Chairman of the Department of Surgery of the Medical College of Virginia, will serve as moderator. Participating in the panel will be Dr. David A. Newman of Palm Beach, Dr. Michael M. Gilbert of Miami and Dr. Robert G. Cushman of Jacksonville. Dr. Newman's subject is "Reversal of Intractable Cardiac Edema." The title of Dr. Gilbert's paper is "The Use of Carbon Dioxide in the Treatment of Postconcussion Syndromes." Dr. Cushman will discuss "The Application of Aspiration Technics as a Diagnostic Tool."

Dr. Donald F. Marion will preside at the Second Scientific Session, beginning at 2 p.m. Two papers on surgical subjects will open the program: "Physiologic Basis for Ulcer Surgery" by Dr. Edward R. Woodward of Gainesville, and "Ventricular Aneurysm" by Dr. Richard G. Connar of Tampa. Following the afternoon recess, a panel will present the medical and surgical aspects of diseases of the chest. Dr. Franz H. Stewart of Miami will preside, and Dr. David T. Smith, Chairman of the Department of Bacteriology of Duke University School of Medicine, will serve as the moderator. The panel members and their subjects will be: Dr. George H. Hames





Drs. Abraham R. Hollender, Miami Beach; Nathan S. Rubin, Pensacola, and Gerard H. Hilbert, Pensacola (left to right).

Drs. David A. Newman, Palm Beach; Michael M. Gilbert, Miami, and Robert G. Cushman, Jacksonville (left to right).








Drs. Edward R. Woodward, Gainesville, and Richard G. Connar, Tampa (left to right).

Below: Drs. George H. Hames, Lantana; William W. Stead, Gainesville; John G. Chesney, Miami, and Hawley H. Seiler, Tampa (left to right).






of Lantana, "Differential Diagnosis of Pulmonary Tuberculosis;" Dr. William White Stead of Gainesville, "Office and Bedside Evaluation of Pulmonary Function;" Dr. John G. Chesney, Dr. DeWitt C. Daughtry and Dr. Harold C. Spear of Miami, "Surgery in the Relief of Dyspnea of Ventilatory Origin;" and Dr. Hawley H. Seiler of Tampa, "Pulmonary Surgery in Infants and Children."

The complete program for the Annual Meeting will appear in the April issue of The Journal. The excellent scientific program, the distinguished guest speakers at other sessions, the important matters to come before the House of Delegates and the many attractions of the Miami area should assure an unusually large attendance.

Popularity of Midwinter Seminar Grows

The Twelfth Annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology attracted the largest attendance this annual gathering at Miami Beach has ever had. Held at the Americana Hotel the week of Jan. 27, 1958, this popular Seminar had 440 registrants from 38 states and from Canada, which had a representation of five. The Florida Society of Ophthalmology and Otolaryngology was well represented this year with 68 members in attendance.

This outstanding event in Florida's excellent program of postgraduate medical education was arranged to allow ample opportunity for afternoon recreation and evening entertainment. The featured social event was the annual informal dinner on Wednesday night, January 29, at the headquarters hotel, which was preceded by a cocktail party for the visitors from throughout the nation.

As is the custom, the program for the first three days of the week was devoted to Ophthalmology and for the last three days to Otolaryngology. The faculty consisted of Dr. Frank D. Costenbader of Washington, D. C., Dr. John H. Dunnington of New York City, Dr. Peter C. Kronfeld of Chicago, Dr. W. Howard Morrison of Omaha, and Dr. C. L. Schepens of Boston, lecturing on Ophthalmology; Dr. Aram Glorig of Los Angeles, Dr. Jerome Hilger of St. Paul, Dr. Alexander S. McMillan of Boston, Dr. Samuel Martin of Gainesville, and Dr. James Maxwell of Ann Arbor, Mich., lecturing on Otolaryngology.

Seminar on Internal Medicine

On April 3-5, 1958 the University of Florida College of Medicine will inaugurate at the medical college in Gainesville a series of postgraduate education seminars. The first seminar is to be devoted to a discussion of recent advances in the understanding and management of patients with kidney, thyroid and respiratory disorders. This meeting should be of interest to physicians in general practice and specialists who are seeing patients with medical illnesses. Selected topics of clinical import will be presented, and ample time will be provided for discussion of individual problems in patient management.

Guest speakers will include Drs. George Schreiner, Georgetown University Medical Center, and Henry Heinemann of the Presbyterian Hospital, New York City, whose subject is renal disorders; Drs. William H. Beierwaltes of the University of Michigan Medical School, Ann Arbor, and J. E. Rall of the National Institutes of Health, Bethesda, Md., who will discuss the thyroid gland; and Drs. William Stead and Arthur Otis of the University of Florida College of Medicine, who will lecture on respiratory disorders. Dean George T. Harrell Jr. also will deliver a lecture on urinary tract infections. Other members of the University medical college who will participate in this seminar will be Drs. Mannie Suter, Chairman, Department of Bacteriology; J. L. Edwards, Chairman, Department of Pathology; Samuel P. Martin, Chairman, Department of Medicine; Thomas H. Maren, Chairman, Department of Pharmacology; and William C. Thomas Jr., Department of Medicine.

Topics to be included in this seminar are:

Renal Disorders: Newer concepts in the pathogenesis and management of patients with acute tubular necrosis; symptomatic electrolyte disturbances in patients with chronic renal disease; renal function—practical assessment and correlation with pathologic derangement; management of patients with acute and chronic infections of the urinary tract; recognition of patients with hypertension due to unilateral renal disease.

Thyroid Disorders: Factors in thyroxin formation and release by the thyroid gland; limitations in the application of newer methods of assessing thyroid function; pathogenesis and management of benign and malignant tumors of the thyroid; diagnostic dilemmas in histologic studies of diseased thyroid glands; recent developments in the pathogenesis of thyroiditis and the possible

application of autoimmune mechanisms to other endocrine disorders; the necessity for critical evaluation of patients with the "hypometabolic state;" hypopituitarism, and often unrecognized though not infrequent cause of hypothyroidism.

Respiratory Disorders: Disturbed physiology in patients with chronic respiratory disorders; advantages and limitations of newer technics used in the treatment of patients with pulmonary emphysema; critical selection and use of drugs in patients with respiratory infections; useful aids in the differential diagnosis in patients with chest disorders.

Advance registration should be made with the Division of Postgraduate Education, College of Medicine, University of Florida, Gainesville. There will be a fee of $25 for attendance at this seminar.

1957 Report of Ford Foundation

The Ford Foundation made new grants and appropriations totaling $83 million for education and other programs of national importance during the last fiscal year, according to the 1957 annual report issued recently. The report covers the period from Oct. 1, 1956 to Sept. 30, 1957. Actions during 1957 brought to more than $1 billion the Foundation's grants and appropriations since it was established in 1936. The largest single grant was $24.5 million to expand nationally the Woodrow Wilson fellowship program to combat the shortage of college teachers.

Henry T. Heald, completing his first year as president of the Foundation, said in the report that "the cornerstone of the Foundation's philosophy and program is the belief that through education society can realize its fullest potential for material abundance, intellectual enlightenment, and moral growth.

"Higher education is beset today by financial difficulties greater than those of any other period in American history. They are the result of a set of circumstances imposed upon higher education by the society it serves, and hence they become the responsibility of that society." Mr. Heald cited as pressures on higher education the larger number seeking education, the demand for more years of education, the expanding fund of knowledge, and the United States' role as leader of the free world.

The year was marked by the ascendency of certain Foundation programs and the completion of others. Among opening grants made was one on the Problems of the Aging. One feature of this new program was a grant of $24,000 to the University of Florida for research into the adjustment problems of persons who move to new communities for retirement.

Three programs completed by final payments from the special 1955 and 1956 appropriations of $550 million were $260 million for college faculty salaries, $200 million for extension of services in private, voluntary hospitals, and $90 million for improvement of instruction in 45 privately controlled medical schools. Fifty-six privately supported hospitals in Florida received payments ranging from $5,000 to $87,000, the payments for the year amounting to $1,115,300 and the total grants to $2,365,900. Among the privately supported medical schools, the University of Miami received a payment of $400,000, completing a total grant of $900,000.

Although the purpose of the Ford Foundation is to serve society and, by extension, to advance human welfare, Mr. Heald said, no foundation or combination of foundations can solve the complex problems and plaguing needs of mankind. "The most a foundation can do is to make a start, or indicate a route, or call attention to an idea. If the direction is right and the method sound, if a solution seems possible, then the people themselves—individually or collectively through their voluntary agencies or governments—will finish the job." In this role the Ford Foundation has indeed made and is making a magnificant contribution at home and abroad.

Newly Established Educational Council For Foreign Medical Graduates

After almost three years of planning, the Educational Council for Foreign Medical Graduates is now in operation at 1710 Orrington Ave., Evanston, Ill. It will distribute to foreign medical graduates around the world authentic information regarding the opportunities, difficulties and pitfalls involved in coming to the United States on an exchange visitor or exchange student visa in order to take training as an intern or resident in a United States hospital, or coming on an immigrant visa with the hope of becoming licensed to practice.

Another function will be to make available to properly qualified foreign medical graduates while still in their own country a means of obtaining ECFMG certification (a) to the effect

that their educational credentials have been checked and found meeting minimal standards (18 years of formal education, including at least four years in a bona fide medical school), (b) that the command of English has been tested and found adequate for assuming an internship in an American hospital, and (c) that the general knowledge of medicine as evidenced by passing of the American Medical Qualification Examination is adequate for assuming an internship in an American hospital. In addition, it will provide hospitals, state licensing boards, and specialty boards which the foreign medical graduate designates, the results of the three way screening available.

This newly organized council will not serve as a placement agency either for interns or residents. Placement arrangements must be made by the foreign medical graduate directly with the hospital of his choice. It will not attempt to evaluate the teaching program or inspect or approve any foreign medical school. Its program is based not upon evaluating the school from which the candidate graduated but upon evaluating the professional competence of the individual. Also, it will not act as an intercessor for foreign medical graduates having problems under discussion by state boards of medical licensure or specialty boards. If the foreign medical graduate asks that the results of his three way screening be sent to a designated board, this will be done, but the ECFMG has no right and no desire to review the decisions of the properly constituted state licensing boards and American specialty boards.

Sponsors of the new agency are the American Hospital Association, the American Medical Association, the Association of American Medical Colleges and the Federation of State Medical Boards of the United States. Providing funds to support it through the first two years of its existence are the sponsoring agencies, the Kellogg Foundation and the Rockefeller Foundation. The Executive Director is Dr. Dean F. Smiley, former Secretary of the Association of American Medical Colleges.

The ECFMG's Examination Committee will select the items for two examinations a year from the National Board of Medical Examiners' pool of questions. The National Board of Medical Examiners will use as many of its 50 presently constituted United States examination centers as will be required and will establish examination centers abroad in numbers as found required to meet the need. The National Board of Medical Examiners will proctor the examination, score and analyze the results, and turn them over to the ECFMG's Examination Committee for final evaluation and action.

The target date for the first American Medical Qualification Examination for foreign medical graduates already in this country was set for February or March 1958, and the second one is scheduled for August or September of this year. The latter will also be available to foreign medical graduates abroad.

OTHERS ARE SAYING

The Art of Setting Fees

As one leaves his internship or residency and hangs out his shingle to signify that he is entering into the practice of medicine, the neophite then begins to wonder about how to set up an office.

Like every soap 99 9/10 are pure and have seldom if ever charged for their services. How does he know what to charge; should he inquire about the charge of others in the community; take the various fee schedules from Blue Shield; industrial commission or medicare or perhaps he should read Medical Economics, Newsweek, and try to hit a happy medium.

Establishment of fees according to some should be set rigid rules regardless of the financial standing of the patient. Others feel that almost all charges should take into consideration the person's ability to pay. Perhaps these floating schedules would be possible and necessary for large fees that result from surgery, long hospitalization periods or in time of real hardship or the so called catastrophe illness.

The average physician must depend on the two to ten dollar fee that comes from office, home and hospital calls. It is kind of difficult to charge different fees for the same service one offers in the office. For this reason each physician stabilizes his own fees so that in general he charges the same amount for his office procedures.

Time, knowledge and skill are the physician's main commodity. He has little else to sell. If he prescribes and sells medicine or sells shots the physician is entirely within his right. Perhaps

better, shouldn't we feel that the doctor is selling his knowledge of diseases, skill and therapeutics.

Charges are difficult to set up as a rigid fee schedule. No one likes rules and unfortunately they are made to be broken. It certainly is not good for public relations for one to give a simple shot for five dollars and then have the patient ask why Doctor Cheaper charges only two dollars for this same shot. It is hard to tell the patient that you have made a special study of this matter; that you autoclave each syringe and needle before use; that you use only high grade injectables, syringes and needles. Still in the patient's mind is the difference between two and five dollars.

Some place in each medical society there should be a committee that should establish minimal fee schedules for office calls and treatments, home calls, which vary with distance and time of day or night, and last of all, a minimal standard for hospital calls and procedures.

Only through this medium can we as a Society establish good relationships with the public that we serve, and, only incidentally, rely upon for our livelihood.

The Bulletin
Sarasota County Medical Society
November 1957

BLUE SHIELD

My View of Florida Blue Shield

ROBERT E. ZELLNER, M.D.

ORLANDO

Member of Florida Medical Association Advisory Committee to Blue Shield

When Dr. Babers asked me to appear on this program, I wondered why. After hearing the array of talent that appeared today, I wonder even more why, but I have finally come to a conclusion. The other night my son, who is in the eighth grade, came home with a book called "The Education of T. C. Mits." I had never heard of Mr. Mits, but the title of the book interested me. I opened it and much to my surprise found that it was an arithmetic book. I then looked back to see what the education of T. C. Mits was, and it turned out that T. C. Mits is an abbreviation for "The Common Man in the Street." So, I think that after all this array, the program committee wants on the program one common man in the street, and that is I.

Something like 18 months ago, Dr. Langley asked me to serve on the Association's Advisory Committee to Blue Shield. It was one of few jobs I have been asked to do that I accepted readily and with pleasure. I had formed some definite conclusions about Blue Shield, and if anybody was going to help straighten it out, I wanted to have a hand in it. Because I found, in casting around and talking to a number of my friends, that the ideas which I had were fairly common, I thought that the way I felt was reasonably representative.

Early Conclusions

There were several conclusions to which I had come:

One of them was that Blue Shield is no longer necessary. It was organized back in 1945 in this state, primarily for the indigent, and the indigent nowadays hardly exist any more. Everybody is paying his bills, everybody has a big automobile, even if he is paying for it on time; so these indigents that we were concerned about just do not come in our offices anymore. Most of us are collecting most of the money that is on our books. Another reason why it is no longer necessary is that when Blue Shield was organized, there was no adequate insurance coverage for medical and surgical expense; but we now have the commercial companies offering all kinds of policies for such expense. And, after all, this is America, we believe in free enterprise, we are all free agents ourselves, we pay taxes in our community, and we do not want to see a nonprofit organization moving in. If the commercial insurance companies can operate at a profit, then they should, and we would get out of this nonprofit business. A third reason why I thought Blue Shield was obsolete is that we have defeated Claude Pepper now, and we have a man that we thought a few years ago was better than Claude, and socialized medicine is no longer a threat; so we just do not need Blue Shield any more.

The two addresses in this issue of The Journal are the third and fourth in a series. The first two were published in the February issue: "Opening and Explanatory Remarks," by Dr. Henry J. Babers Jr., and "Blue Shield From the Layman's Viewpoint," by Judge Ben C. Willis. All the addresses were delivered at the meeting of Active Members of Florida Blue Shield held Dec. 7, 1957 in Jacksonville.

A second conclusion to which I had come was that if we are going to keep Blue Shield, it should sell to indigents only. Why should we get out in the commercial market and compete for groups financially able to pay their own way? Our job is to take care of these people in the indigent groups, and help them to help pay us. We are the people who are helping to take care of them for nothing; so when we make it possible for them to pay through insurance for care they would otherwise have gotten for nothing, in effect, we are scratching our own backs. If, however, we are going to sell, let us sell to those people only.

The third conclusion to which I had come was that the Blue Shield management is no longer interested in the medical profession. Mr. Schroder started out with us in a small organization. He has built it, along with the medical profession, into a multimillion dollar organization. It is a pretty big concern, and it is characteristic of the bureaucrat that if he can make it bigger, make more money, it gives him more prestige and makes him a bigger figure on a national basis. I felt that the directorship of Blue Shield no longer represented me. I was confident that most of the directors must have made their pile before the war, or, what was worse still, during the war. While I am doing all right, I have not bought my first Cadillac yet; and I still find that while I have myself insured against every contingency, my family and I manage to live it up and at the end of the year I do not have anything left. I am still making my first million and I did not feel that this representation which we have on the board of directors was. So, if there was going to be any change in Blue Shield, then I wanted to have a hand in making it.

Changed Viewpoint

Today, 18 months later, I think possibly the reason I am on this program is that I am like an alcoholic who joined Alcoholics Anonymous. The committee made a sucker out of me in that I have had to eat humble pie, and rather than thinking Blue Shield is no longer necessary, I am convinced that it is now more necessary than it ever has been before. I did not know just how necessary until I heard Mr. Ketchum and Dr. Good today. First, I think that the existence of Blue Shield shows that we care, that the medical profession cares. We have been accused of doing nothing, being negativists, always being against and maintaining the status quo; but this is positive action which we have actually taken, and it shows that we are interested in solving a problem which is going to be solved one way or another.

Secondly, there has been a tremendous change in the attitude and the atmosphere of the American Public in so far as buying things is concerned. This has been alluded to already. Everybody pays for anything he buys now at so much a month. I am no exception. I bought a house not long ago and I was not at all concerned about what it was going to cost. I wanted to know what my mortgage payment was going to be each month. I think the rest of us are pretty much in the same boat. I would like to point a finger at my own county medical society, which now lets members pay its dues twice a year. We are on an installment plan. Everything that we buy nowadays is on the installment plan, and people are now buying their medical care on a prepaid basis. So, what we are doing is simply collecting the fees in advance and then apportioning them among the profession.

Another reason why I think Blue Shield is necessary is that it sets the pace for the commercial companies. Who knows what would happen if this brake were removed? These companies are saying, "This is as good as Blue Shield and it costs less." "This is better than Blue Shield because such and such." It actually is setting a pace for these companies and to show you how important these commercial companies consider the type of policy which Blue Shield sells, most of you remember, I know, that just recently the Florida Power and Light Company down on the southeast coast proposed a commercial service plan. I can just imagine what representation any one of you men would have had if you had decided that the fee schedule was not equitable. You are one voice, one man against this commercial carrier, and have absolutely nothing to say about it. However attractive it was to begin with, no one knows what it would be next year or five years from now. We have absolutely no control over any commercial carrier, which is not true of Blue Shield. It is adequately demonstrated by this chart here giving names of the directors that we do control Blue Shield. As I look over these names I do not know who is driving the big cars, but I see one fellow over here, George Palmer, who was a year behind me in college. I do not know if he has a rich uncle, but I imagine he is buying his groceries on the in-

stallment plan as I am. I look at several others here, and there may be some wealthy ones among you, but if there are, I do not think they made it in medicine. It seems to me that we have a pretty good representation of Mr. T. C. Mits.

I would like to read a statement here to show you this is not simply a local problem. This was written by Dr. Morris K. Carothers of Oregon. I do not know Dr. Carothers, but I think this is a statement which could well have been written by any one of us. "I think there is no doubt that most physicians would infinitely prefer to be left alone to practice their profession to the best of their ability and in the light of their conscience and not be forced to participate in the perplexing problems now being imposed by the very existence of health insurance. For the existence of insurance has of itself, increased the amount of medical care that is rendered." We all know that this is true and that people are not only seeking medical care because it does not mean money comes out of their pockets today, but the existence of this type of insurance is enabling them to have better medical care than they have ever had before.

"The difficulty is, of course," Dr. Carothers continued, "that while there is only so much money in the treasury of the health insurance companies, there is an unlimited amount of services to be rendered and almost all of it can be theoretically justified. It is the belief of many who have studied these problems that the traditional devices of casualty insurance companies, namely the deductibles and co-insurance provisions, will not, of themselves, be sufficient to provide adequate controls upon a spiraling cost of medical care. At least in the present frame of mind of the public, it does not seem likely the contracts can be sold with deductible and co-insurance features high enough to act as a sufficient control. Since there are more and more funds being poured into health insurance plans and coming under the control of business men administering these plans, there are going to be increasing problems of the relationship of these so-called third parties to both the patients and the doctors. Many of us believe that it is essential that physicians take an active and constant interest in these matters. We believe that the balance that must be found between economic reality and medical idealism is one that can be found only with the participation of physicians in the decision making. Physicians must be in the inner councils."

As you can see, we are in the inner council, as has been brought out before by the composition of the board of directors. I have mentioned here that I think these men are doing a good job. I also have to eat more humble pie. I have had to change my mind about Mr. Schroder. I had some harsh thoughts although I have not said them all out loud. Some of the harsh ones I thought, but I would like to take those back, the ones I said out loud as well as the mental reservations. I think he has done a fine job and I think, too, that his forbearance and his self control with people like me, uninformed, opinionated, and positive, making statements, unsubstantiated, are as remarkable as they are rare. I think that he has much more self control than I would have, and I want to say publicly that I have had to change my mind and that I was entirely wrong.

Earlier, I made the point that Blue Shield should be sold to indigents only. In the first place, this cannot be done. As has been brought out before, there is a higher rate of utilization of these services by indigents, and Blue Shield, by having a community rate, does in effect what we as doctors do in our offices. We charge some people more in order to charge other people less. If we only insured the indigent people, then the rates that would necessarily have to be charged would be substantially higher than the indigent could afford. Consequently, we must insure some of these preferred risk groups in order to get the community rate at a level the people can afford. The commercial companies have no interest in the social aspect of the medical needs of low income people. Nor are they interested in the doctor. The one interest which they have is in marketing a product which can make a profit. Admittedly, this is a praiseworthy motive, but this leaves the doctor holding the bag when he takes care of people who cannot afford to be sick and who cannot afford or qualify for commercial insurance. By skimming off the cream, the young people, the people who are healthier, those who are better fed, and those who have better preventive medicine, commercial carriers are able to charge a rate less than Blue Shield; but they carefully avoid the very people who need insurance most.

There is another reason, before I pass it over, why I think that it is necessary for us to have Blue Shield. Almost 90 per cent of the funds collected by Blue Shield are returned to the physician. There is almost a 10 per cent main-

tenance charge, or handling charge. I had a book put out by the insurance industry about four years ago. I think it is called Best's or something like that. Such books are hard to get hold of because they are restricted to insurance company executives. One of them inadvertently left a copy in my office. It contained some information which I was glad to have. At that time, there was not a single commercial insurance company in the United States which returned as much as 60 cents on the dollar to medical and surgical policyholders. White Cross, for example, paid back something like 40 cents out of every dollar that it collected. You can see what happens. If there is any money to be made out of caring for sick people, I do not think it should be made by stockholders, or by banks or by insurance companies. I think it should be made by the people who are rendering these services. It is the doctor alone, not the banks, the insurance companies, or other investment concerns, who pays for the indigent's medical care. It is only reasonable, then, that money collected for doctor bills should reach the doctor's pocket. Blue Shield and Blue Cross distributed to the doctors and hospitals in Florida last year the sum of 15 million dollars, which was 90 per cent of the premium collected. If we expand that up to 100 per cent, that means that they actually collected about 16.25 million dollars, of which we and the hospitals got back 15 million, more money than was distributed in this state by any other insurance company. That includes money paid out on all types of insurance; life, hospital, health and accident, and everything else. They distributed, here, 15 million dollars among us. Just suppose that had all been done only by commercial companies. Then the amount that they would have had to collect from the people of Florida, rather than 16.25 million, woud have been around 30 million dollars, a good part of which would have been distributed among stockholders. If anybody is going to make money off my services, I want to be that person. There, then, is one of the other reasons why I think that Blue Shield is so necessary to the medical profession.

Another point which I made about my objections to Blue Shield was that it was no longer interested in the medical profession. I referred to this earlier and I am convinced after attending their board meetings and watching them work that these people are interested. Most of them are doctors, and they have the same problems that we have. The others are lay people of unquestioned repute whose only compensation for serving on the Blue Shield board is what personal satisfaction they get from doing a worth while service for the community, the same compensation any one of us gets for serving on the community chest, Red Cross, or other such organizations. One of the things that I have found in serving on this committee is that in a highly controversial area, neutrality itself is suspect. There is no such thing as a neutral; it is "you are a friendly neutral on what side," or "you are unbiased in which direction." I know I suspected all these people, and because I have changed my mind about some of these things, with more information, I find that I myself am becoming suspect. I have been told, "You have sold out to Blue Shield." I think Dr. Babers has already alluded to my hard head, and I sincerely believe that I am harder to brainwash than that. I sincerely believe, too, that any one of you gentlemen subjected to the same education here as Mr. Mits and I have been would come out pretty much in the same mind.

Problems

I have come to some conclusions about what should be done with Blue Shield and I have just about decided, after hearing today's talks, that I may be wrong on this score, too. The more I learn the less I know. There are some things that seem wrong with Blue Shield, some things inherent in its makeup, which, although not actually wrong, predispose it to trouble. We have in effect, comparing Blue Shield with commercial companies, a democracy versus dictatorship. We know that it is an easy matter for Russia to suppress news. We have had a good example of how we can make monkeys of ourselves with the Vanguard mess yesterday and the day before. We do not know how many times the Russians fouled up before they put their satellites in the air. They do not have to explain those things to their people. Somebody decides, and that is it. In this country, however, we have to persuade people. We have to persuade them we are doing the right thing. I heard Edward Benes, who, you will remember, was the prewar premier of Czechoslovakia, say in this country, during the so-called cold war stage in 1939 and 1940, that the Nazis destroyed Czechoslovakia by utilizing those very things of which the Czechoslovakians were proudest, those things based on the American constitution: the right to assemble, freedom

to bear arms, freedom of speech; and by misusing them, they were able to destroy them. He was not suggesting that those things should be curtailed here or elsewhere. He was suggesting, however, that with freedoms of that sort come certain responsibilities to hold certain elements in check.

We have the same situation here. I can not conceive of the Metropolitan Life Insurance Company or, less still, of the Bankers Life & Casualty Company calling a hundred or more doctors together to ask what they think about their policies. The very fact that a meeting of this sort would be held should indicate the interest of Blue Shield and indicate the difficulties that Blue Shield has. Any employer can go to Metropolitan today, or Prudential, and tell them what he wants. Suppose he has a company that has a thousand employees he wants insured. He tells them what he wants, and three days later they can give him a contract. We found in the Medical Economics Committee in negotiating with various companies for the Health and Accident plans for the Florida Medical Association that when one is dealing with a half million dollars, he can buy what he pleases. You do not ask them for a contract; you tell them what you want. That is about the premium (half million dollars) that would be developed in this Florida Medical Association Plan per annum, which is small potatoes compared to Blue Shield.

So, when you deal with that kind of money, you can buy what you want, except from Blue Shield and Blue Cross. They walk into a company and say, "This is it. Take it or leave it." "Why?" the employers want to know. Because this is what the doctors say we can sell, they are told. The very makeup of Blue Shield makes it difficult for it to meet the changing situations which it has to face. Is that all wrong? Should the doctor's feelings be ignored just because the commercial companies have no interest in them? Should we change the whole setup to meet competition? I think it should be changed some, to make it possible for Blue Shield to meet some of these situations, but not changed so much that the doctors voices are stilled, or are not important. Nor should it be changed so much that such a meeting as this would no longer be necessary or desirable.

Another problem which faces Blue Shield is the divergent opinions among the doctors. I have on my desk something like a hundred letters which have come in the last month in response to the questionnaire which we sent out. We run into this sort of thing: "What is wrong with Blue Shield is that it is paying too much; it is paying for unnecessary things in the office. It has no business paying for office cervical cauteries, office warts, things of that sort. What I would like it to do is have you pay more for the big things. It has no business paying for little stuff." Turn the next page, and here is another one. "What is wrong with Blue Shield is it does not pay for office care. You are loading up the hospital with people who do not belong there simply because doctors are admitting them to have diagnostic work-ups." All of such comments are made in perfect sincerity and equally perfect ignorance. A statement about the hospitals being loaded up because of misuse of hospitalization insurance is something which we suspect, and something that is exceedingly hard to prove. I pick out the one or two cases that I know about and draw generalizations that everyone but me is loading up the hospitals. This halo only has one size and it only fits one head, and each of us suspects the other fellow of being just a little bit crooked.

A fourth thing that I think is wrong is the influence of the specialty groups. I do not know to what we could attribute this. I do know that since the war, at the state meeting, instead of all going to the annual meeting of the Association, many of us have started going on Saturday, going to our own specialty groups and heading out for home. Instead of being physicians, we have become surgeons, orthopods, pediatricians, anesthesiologists, obstetricians, and internists. We no longer are members of the Florida Medical Association; we are members of our own specialty groups, and, to say the least, we all have a fairly narrow point of view when it is confined to that particular group. I think it is absolutely essential that once more we become physicians, that we become greatly interested in the problems of medicine, rather than the problems of surgery, the problems of orthopedics, or the problems of any specialty group. We must take an interest in this thing in so far as it affects all of us, because if one of us sinks, all of us sink. We have here in this state a problem that is not confined to Florida, the matter of adequate payment for medical services. It is a problem which must be solved, because we cannot have any segment of the

medical profession which is not wholeheartedly behind Blue Shield.

There is one other difficulty I would like to mention, the rigidity of Blue Shield. There are many things which apparently should be changed which it cannot change. Some of its severest critics are saying, "You should not pay for this, you should not pay for that." I know any one of you could sit down here and in a few minutes write out a formula for tube feeding that would meet the necessary nutritional requirements, provide all the carbohydrate, all the protein, all the vitamins, all the minerals, all the things that would be absolutely necessary to keep a person in the best of health, but who would want to eat the stuff? You have to put it down with a tube, or else nobody is going to eat it. I am sure that given an hour or so, I could write out an insurance policy which would be exactly what my patients would need, something which would suit them well; but they are just like me in this respect. They like to eat turkey dinner, too, and do not want to be fed something that is good for them but which does not taste good. I am sure most of you drive automobiles with much unnecessary chrome and gingerbread on them. You buy them, and pay twice what they are worth, because of a stripe across the top or down the side, or a button on this side of the steering wheel instead of that side. There may be no difference in the automotive construction of the automobile, but you change your model because the hub caps look different from last year's model. Blue Shield has to be competitive. It has to offer some things in its contract which are really tomfoolishness, simply because these people, who after all are the ones who are going to decide just how good it is, are going to have to buy it. They do not have to buy it, actually; but if they are going to buy it, it has to be desirable.

There are several alternatives which face us. One of them is to maintain the status quo. As Dr. Good has said, I hope that nobody elects that, because I think it would be better to vote Blue Shield out of existence than to let it die a death of attrition. I have heard it said that if we lose one big group, the Dade County Teachers' Association, Blue Shield is going to be out of business, because they are a preferred risk group. Their low utilization rate enables Blue Shield to sell many other policies to older or less desirable people at a lower rate, one which they can afford, than would otherwise be possible. If it loses the several hundred, possibly thousand, members in that group, then with the preferred risk people gone, Blue Shield cannot afford to underwrite the indigents. So the status quo is not a solution, it is a conclusion.

The second thing that we can do is offer an indemnity contract, completely indemnity. I am not going to say anything more about that, because I think that Dr. Good and others have said enough about it. I am convinced that the service principle is important for two reasons. One is that it shows we are interested and we are interested enough that we will give, and the second thing is that it makes us unique. We as doctors and we as members of Blue Shield have an interest and, I might add, a stake in the health and the medical problems of the entire community rather than in the preferred risks only. The old, the indigent, and the poor risk are going to receive medical attention somehow, either through insurance which they can afford, from us for nothing, or from the government. If we go into the strictly indemnity type contract, we have nothing to offer which the commercial company does not have.

Constructive Measures

I had made up my mind to say a little bit about the things that I think should be done. After listening to the talks of the last hour or so, I am not so sure that I know all the answers. There are several things, however, which have become self evident to me in the past year and what I have heard here today increases the strength of my convictions:

1. The service income limits of Blue Shield must be raised to a level high enough to attract a sufficient number of middle income subscribers to enable Blue Shield to underwrite the medical indigents, the elderly, and the other poor risks at a price they can afford to pay. Just what this level will be will be determined by what is acceptable to the doctors of Florida.

2. The scope of services covered by Blue Shield must be broadened to the extent that it is truly a medical and surgical contract.

3. The fee schedule must be completely revised so that certain gross inequities in the present schedule are eliminated and so that fees commensurate with increased service limits are paid.

4. Some system for permitting Blue Shield to change its contracts to meet changing conditions must be devised. At the present time, this has to

be presented at the annual meeting of the House of Delegates, which makes the whole setup so rigid and cumbersome that it neither serves the best interests of the doctor nor of the subscriber. One solution might be to do as they do in Massachusetts where the Board of Governors of the State Medical Association is empowered to authorize changes in the Blue Shield contract. Another possible solution would be to permit the Committee of Seventeen to approve such changes, although I think the Board of Governors would be better. Whoever it is should have the respect and confidence of the entire Association and should be conversant and interested in the problems of both Blue Shield and the medical profession.

5. A continuing campaign for the dissemination of information about Blue Shield and Blue Cross problems is another must. If the same effort expended in the past 18 months by the Committee of Seventeen had been spent six, seven, or eight years ago, I firmly believe that many of the problems and much of the misunderstanding about Blue Shield in the past several years would never have arisen.

I do hope that you gentlemen will understand that our interest in this matter has been in doing to the best of our abilities a job that was given to us by the Florida Medical Association, by you, some 18 months ago. It has been the hardest job that I have had to do in medicine during the period of my membership in this Association. It has been a headache in many respects, and unless something comes of it, unless we can get back to the members of the society itself the information which we have been able to distil out of what we have learned, our time has been wasted. I sincerely hope that what you have learned from what has been said here today, you will take back, and that as a result of the information which we have been able to accumulate, come next spring, we will be able to come up with a solution that will be acceptable to the members of the Association, which will be salable to the public, and with which Blue Shield can live.

Blue Shield Annual Meeting

The annual meeting of Blue Shield will be held Monday, May 12, in the Bal Masque Room of the Hotel Americana, Bal Harbour, Miami Beach. The session begins at 4:00 p.m.

Blue Shield Yesterday, Today and Tomorrow

JAY C. KETCHUM
DETROIT

Executive Vice President, Michigan Medical Service.

The development of medical prepayment plans, Blue Shield Plans, from the very beginning was built around the idea of freedom of choice. I was pleased to hear Judge Willis, a member of your Blue Shield Board of Directors, use the term "freedom of choice" because it leads right down to almost all that I have to say. More important than the freedom of the patient to choose his own physician, and the freedom of the physician to participate in your Blue Shield Plan and to accept or reject a particular case or patient, is the freedom of choice exercised by the profession to accept or reject prepayment by Blue Shield as a principle or policy. You made this choice in Florida in January 1946, when you established Blue Shield of Florida, Inc. In any attempt to evaluate medicine's position in relation to prepayment, and to determine its course of action for the future, it is logical to think back and to consider the past: how and why you are where you are and the choices you made which brought you to this situation.

Dr. David B. Allman, the present president of the American Medical Association, in an article published in the Journal of the American Medical Association, Nov. 23, 1957, expressed this point: that medicine did have, and had exercised a choice in regard to Blue Shield. He wrote, "Ideally, physicians believe in the provision of medical service on a fee-for-service basis; a market in which a multitude of individual purchasers of medical care can choose freely and voluntarily the physician they want. The free choice concept is obviously not confined to medical care. It is a basic concept of our American system. Clarence Randall, in his book "The American Way," makes this explanation: 'The outward manifestation of the American system at work is freedom of choice for the individual in every activity of his life. The more that society can contrive to leave him free to select the aims for his life and the means of satisfying his own needs as he conceives them to be needs, the more willingly will he give of his best efforts in order that those ends may be attained.'

"Under these circumstances," Dr. Allman continued, "medicine operates in a competitive cli-

mate that fosters incentive, rewards ability, and smothers mediocrity. But medicine has had to yield, although its basic tenets remain. It yielded to financing mechanisms that clearly restrict the seller's right to price his service, when it was convinced that the only alternative was submission to less acceptable conditions. Physicians, for example, in many areas developed and participated in Blue Shield Plans of the service type . . . because they felt even less desirable third party control would have ensued had the profession itself not sponsored prepayment service type plans.

"From the beginning, the profession was split on this question of sponsorship of service type benefits. And today the controversy continues. Many consider that physician-sponsored plans must stress service or cease to exist, while others condemn the approach as paving the way to control of medical practice by third parties. Even among the service advocates intense controversy exists in connection with the income level at which the service benefits are to apply. Some demand low income levels so as to assure a self-contained, relatively limited, program, while others maintain that the plan serves neither the public nor the profession well unless the income level is increased so that a reasonably large section of the public can be covered. You are familiar with most of these considerations. . . . I mention them only to emphasize the point that the physician has, by the pressure of events, come to play a more important role in financing mechanisms than he ever conceived would have been possible only a few years ago."

Obviously, if Dr. Allman is right, and I think he is, medicine, in sponsoring Blue Shield, chose the lesser of two alternative evils. Also, obviously, you are here to attend his meeting of your House of Delegates tomorrow for the reason that you now find yourselves, by the pressure of events, again called upon to make a choice. While you still have your freedom of choice, you are not free from the necessity of making a choice, and again, it may be only the best of poor alternatives.

Michigan's Experience

The invitation to come here and speak to you at this meeting was probably extended to me because my state of Michigan has just gone through and concluded what you are obviously now starting: a re-examination, a whole fresh look at your position in prepayment, particularly your Blue Shield. There may be some considerable difference between my state of Michigan and your state of Florida. I wish I could say my state of Florida. I am sure that in this matter of the economics of medicine and Blue Shield, the differences are only of degree. The nature of the problems and the pressures are undoubtedly the same. In May 1956, I attended the meeting of the Council of the Michigan State Medical Society. I often attend these meetings to report the progress and problems of Blue Shield and to discuss such matters as our Home Town Care Veterans Program and Medicare, which we administer for the society in Michigan. Because of this close relationship, I feel almost as though I were an employee of the state society, as well as of our Blue Shield Plan. At any rate, at this meeting in May, I expressed to the Council considerable concern and doubt that I had been feeling for some time in regard to the future of the Michigan Medical Service, Blue Shield, as well as Blue Shield Plans and Medicine's attitudes and positions throughout the country.

The Michigan society entered into Blue Shield much as the rest of you did, as the lesser of two evils. We got into it long before you did in Florida because the pressures were evident and were felt much sooner and to a much greater degree in Michigan. After some labor pains and some digestive upsets during its early infancy, the Plan began experiencing a surprising and, sometimes, terrifying growth. As far as size and enrolment, number of participating doctors, and financial aspects are concerned, the Plan can be considered successful.

It was this apparent success, however, which gave me concern and some doubts. Our subscriber contracts have always been limited as to the scope of benefits. Although we provided, and still do, medical, surgical and obstetric care for almost all hospitalized illnesses, as well as certain specific procedures of surgery in the doctor's office, we have never gone into diagnostic services, x-ray therapy, physiotherapy, the ancillaries nor the auxiliaries of supplemental services, if I may use those terms, to the basic medical services. We enrolled nearly half the population of the state of Michigan under these very limited contracts. More and more as time passed, we began to hear requests. Unfortunately, in Michigan, we often consider requests to be demands because of the nature of the organization of our population in labor unions. These requests came

from large labor organizations. They came from industry itself; Ford, General Motors, Chrysler, as well as numerous smaller concerns. The profession, too, had ideas about the expansion of Blue Shield into areas which we had not previously covered—some difficult areas, from the actuaries, underwriters and managers point of view. There were also, on the part of the profession, particularly in different specialized groups, constant complaints about the inequities in fees. At any rate, the obvious success we had had in a limited way seemed to indicate to our critics, our public, and our profession that if we just tried a little harder, cast aside some of our fears, our doubts, and our inhibitions, we could probably do pretty well in covering this whole field of medical service, and pay what they consider more equitable, adequate fees.

Locally, labor, among others, was criticizing us severely, and in about the way expressed by Dr. Morris Brand, who is the Medical Advisor to the UAW-CIO, and now to the combined AFL-CIO. In the AFL-CIO News, in December 1956, Dr. Brand stated that since the Congress has not enacted legislation to set up a national health insurance program, which most labor unions favor, unions have had to find other sources of health insurance coverage for their members, mainly Blue Cross and Blue Shield and commercial carriers. "Since home and office care is rarely offered in these plans," Dr. Brand continued, "some labor groups have established direct service medical centers where services are actually provided rather than indemnities to cover part of the cost. The latter type of plan has proven much more popular with members, because there are no barriers to the service. Preventive services are usually included in the benefits, and there are no hidden bills cropping up after the services are rendered." In general, he thought, the extent to which commonly available insurance programs meet the family's health needs is not too impressive to labor. He said that idemnity payments, a base upon which some physicians too frequently add substantial charges, are not a satisfactory method of paying for services. Also, the emphasis on hospital and surgical coverage, as in the case of most plans, without substantial outpatient benefits, is frequently a cause for unnecessary hospitalization. Furthermore, as a result of inadequate concern for operating efficiency in hospitals and an unwillingness to enforce legitimate controls, there are unjustified premium increases.

According to Dr. Brand, these are labor's goals for better health plans: 1. Complete prepayment for medical care without co-insurance and deductible features and hidden added costs. 2. Comprehensive benefits. Only if the range of health services is complete, will the individual's health needs be effectively and economically met. 3. Rational organization of medical services on the basis of group practice, and control of the quality of medical services which must be built into medical care plans. In April 1957, Walter Reuther, the president of UAW, in his presidential address to the convention, confirmed that as being labor's position. In the meantime, Mr. Reuther in Detroit had been proposing a laying of the groundwork for the United Automobile Workers Sponsored Program, Community Health Association. This, as near as we have been able to determine, and it is not off the ground yet, will operate as a closed panel practice group, utilizing salaried physicians, either full or part time, contracting with hospitals for some facilities and perhaps constructing some clinic facilities of their own. While providing a comprehensive scope of services, the diagnostic and preventive services would be stressed.

The Council of the Michigan State Medical Society, recognizing that prepayment was becoming much more than had been contemplated in 1940, decided to engage in an all out effort to educate its members to the facts of the situation to help them reach a decision as to the future of Blue Shield. This effort consisted of informing the profession of the problems and the alternative possible actions, which might even include getting out of Blue Shield as you obviously have considered in Florida. Beginning with the special meeting of the House of Delegates in April 1957, every practical means was utilized to inform the profession. We used the Journal of the Michigan State Medical Society every month. The county society bulletins month after month carried informative articles. Meetings were held through county societies, councilor district meetings were utilized, and the staffs of hospitals were gathered together. Panels of society officials, public relations people and Blue Shield personnel traveled up and down the state to present information at these group meetings and to answer questions. The delegates at this special meeting of the Michigan House of Delegates in April

were asked to take no action at that time. They were informed as completely as possible and because there was need for more information than was then available, two surveys were authorized at that meeting. The only real action that was taken was an authorization to spend the money to make a survey of the public's attitudes and opinions toward prepayment in health insurance and to survey the attitudes, opinions and desires of the medical profession.

Surveys of Public and Professional Opinion

A report on the results of this survey is an all day job in itself. The printed results from that survey weigh 4½ pounds in the original form, in which they were produced by mimeograph. I understand that in Philadelphia last week, bound copies, in a reduced size, were distributed to all the delegates of the American Medical Association and other interested people at the meeting of its House of Delegates. The only part that Blue Shield had in that survey, on which the Michigan State Medical Society spent $20,500, was paying for the binding and printing of this reduced size copy which was distributed at Philadelphia. This was the Michigan society's survey, including 60,000 responses from the public and 1,200 scientifically selected personal interviews.

A total of 60,000 responses were received from questionnaires printed in two of the largest leading newspapers in Michigan. The society also received about 20,000 responses to questionnaires mailed, on some sort of a scientifically selected basis, to people throughout the state, with the numbers in each area being selected in proportion to the population. The survey of the profession resulted in a 35 per cent response from the individuals, physicians, county societies, and specialty groups. During this time, however, the House of Delegates had appointed a special study committee, and we went you one better; it had 18 rather than 17 members. The council also appointed a special study committee; as I recall, there were nine members appointed by the chairman of the Council. The two committees were to do exactly the same job independently of each other, coming back to the regular meeting of the House of Delegates, which was held in September at Grand Rapids, to make a report of their findings and recommendations to the House of Delegates. Results of the public opinion and doctors survey were related to the findings and recommendations of both committees, and it was startling to see the similarity in the findings of these two independent committees. The program of recommendations, drawn up by these two committees, one in rather general terms and one in rather detailed specific terms, was supported right down the line by the findings of the surveys. As a consequence, after hearings by a reference committee of the House of Delegates, which in total lasted something like 18 hours, and went on two nights until after 2 a.m., with all having a chance to express themselves, the House of Delegates on the third day, unanimously, without one dissenting vote, approved a whole new program for Michigan Medical Service.

New Michigan Program

That program gave approval, for the purpose of establishing fee schedules by Blue Shield, for the use of the California Relative Value Scale of surgical, medical and related procedures, with the Michigan State Medical Society setting the dollar factors to be used in connection with that Relative Value Scale for the purposes of our subscriber contracts. I could spend some time, I think, expressing my idea of the value of the Relative Value Scale to be developed by state societies in this area of prepayment, as well as in the area of Medicare and other programs with which you are ultimately going to be forced to cooperate in the provision of medical services for the people.

Perhaps the most advanced step, after adopting this program which includes service benefits for people earning up to $7,500 annually, was the basing of income limits upon the base wage or salary rate of the subscriber. This $7,500 is not family but individual income; and he may earn or receive twice as much income, or 10 times as much income from investments, from other members of his family, and from other sources. Whatever his base wage rate is, not including overtime or bonuses, will determine his income status for the purposes of Blue Shield contracts. There will be three income levels, one $2,500 income, one $5,000, and one $7,500. One at $10,000 was almost adopted because the doctors in Michigan, after studying this problem for months, have decided that even the $30,000 a year executive, these days, if he is stricken with severe illness or injury, is only three months away from bankruptcy. This may be hard for doctors to understand. The $30,000 a year executives would have to sell their yachts to pay doctors' and hospital

bills, and I mean that literally. We live it up just as fast as the little guy who earns only $4,000 or $5,000, and we would be in just as tight a pickle if we were stricken as he would be—primarily because Uncle Sam takes most of it before we get it.

The Michigan State Medical Society made a great advance in the establishment first of a State Society Health Insurance Committee, and under that committee, in councilor districts, health insurance committees to operate at the local community level for the purpose of arriving at, promulgating, enforcing and administering rules and regulations for the conduct of prepayment health insurance—not just Blue Shield, but commercial as well. These were not advisory committees that they were talking about; they used the term, policing committees, to see that the plan worked as it was intended to work for the public and for the doctors. Unfortunately, the time I have been alloted here could all be spent on talking about the necessity for such committees if these programs are going to work as the public has a right to expect them to work. I am not implying that doctors are dishonest, or at least any more so than any other group of citizens, but policing is necessary whether we have the substance or not so that we can satisfy our opponents in this field of health care that everything is being done that needs to be done to assure proper operation.

Years ago, I was the Chief Examiner for the Insurance Department of Michigan, where we employed young men, just out of college. These young men, other than their college experience, had traveled little; at least they had not traveled on expense accounts as they were then. They were not generous expense accounts, but there was enough so that if a fellow were inclined in the evening, he could go out on the town and have a pretty good time. We had to impress on these young men that in this position as public servants, particularly dealing with financial institutions, some of them of doubtful character, we, as examiners, could not afford to be seen out on the town. They used to express it this way for these young men, 'you not only have to be honest, you have to look honest!' That is what I mean by the substance of these regulatory committees as well as the form.

The medical profession throughout the whole country is more or less going through this same process that Michigan went through, and that you are now going through in Florida. The need for consideration and action is evidenced by many, many groups of our public, and you must consider these public attitudes. This Community Health Association proposal in Michigan which will amount to a closed panel practice scheme, is not just our problem in Michigan. We have UAW labor groups in every one of the 48 states in the Union. I do not know how many subscribers Blue Shield of Florida and Blue Cross of Florida cover for General Motors, Ford and Chrysler, but I would gamble that there are groups covered by your local Plans for at least two of these corporations, and probably numbering in the hundreds. Mr. Reuther is not going to be satisfied to organize and operate this Community Health Association just in the state of Michigan. If he were satisfied, he could not get away with it anyway, because what he does for his labor people in Michigan, he is going to have to do for all of them, wherever they are.

Mr. Reuther is not foolish; he is one of the smartest persons I know. He knows that he is not going to have a plan operating covering six or seven million people across the nation by tomorrow. He is going to operate this proposal as a pilot study for some time, and find out what the problems are, and how susceptible the profession is to working on salaries for unions. We do not expect Community Health Association to amount to anything for five or six or seven years, even in Michigan, as far as size and volume are concerned. Nevertheless, it is a threat that you must consider when you make your decisions because after he makes his pilot study and finds out what his problems are, then you can look for expansion and not just by Reuther, but almost all of labor, if it works. Whether it works will depend upon Medicine and hospitals.

Care of the Aged

Some of these unfilled needs in Blue Shield which are expressed to us have to do with special categories of people. One of the great and one of the most immediate problems that medicine and prepayment must deal with is the care of the aged or elder citizens, the retirees. Unfortunately, in our economic climate, this is a growing problem. It is a growing problem, also, in that the expectancy of these people has been extended. Their lifetime has been extended by you gentlemen and by hospitals. Two years ago, there were 14 million of these people who were over 65 in

this country. Today there are around 16½ million. Two years from now, no one knows what the number will be.

These people so far have been unable to obtain for themselves health insurance coverage from the Blue Cross and Blue Shield Plans, to any great extent, and definitely not from the commercial insurance companies, or any other source. They are becoming a vocal, highly organized group of voters. We hold conferences on the aged two or three times a year in our universities in Michigan, and such conferences are going on all over the country. These elderly citizens are finding spokesmen, and they are employing spokesmen. They are paying lobbyists, and they are going to have health insurance coverage, one way or the other. There are in the Congress now, pending hearings, the Forand Bill and the Roberts Bill. The Roberts Bill provides hospitalization coverage for beneficiaries under OASI. The Forand Bill provides hospitalization and surgical care for the beneficiaries under the OASI. So, with our Social Security taxes, we will be paying, if such legislation should come about, for the care of these older people. This is what you term socialized medicine if it comes about, and it will come about, unless something more than a position of opposition is taken by Medicine and prepayment insurance.

I happen to be on the Government Relations Committee of the Blue Shield Commission. There are only three of us that deal with legislation in Washington on a national level as a committee. I am also on the American Medical Association Study Committee on Prepayment Medical Care Plans, one of the two laymen who got caught in that one. As a member of these groups, I have to study these bills, and on many matters such as Medicare, I have had to testify at hearings in Washington. Although the American Medical Association and Blue Shield Executive Committee in Philadelphia, last week, came up with a statement opposing the Forand Bill, I would hate to be the fellow who has to go to Washington and try to convince the legislative hearing committee that this is not needed, that the answer is available through voluntary means. We could have an answer to it if we were able to control prepayment as some of us think we should be able to, and probably would be able to do if the medical profession understood the problem that is involved here.

Until recently, not much has been done about these people who are not employed in groups: the individuals, the farmers, the self-employed. We in Michigan Blue Shield have been doing something; we have been feeling our way in it. Much more is going to have to be done, because some of these people are organized in groups, speak with a loud voice, and hire lobbyists.

In a few words, we are convinced that everyone must have the opportunity to obtain good health insurance coverage at reasonable cost, if we are to retain the freedoms in medical care which are now left to us. The medical profession, having created Blue Shield and having encouraged the public to depend upon the voluntary insurance mechanism as the answer to the problems of financing health care, is now held responsible for the conduct and the results of prepayment on a voluntary basis. This is understandable and is logical, but having taken this position and held it out as your idea and your alternative, you are now held responsible for making it work. Repeating part of Dr. Brand's statement, "also as a result of inadequate concern for operating efficiency in hospitals and an unwillingness to enforce legitimate control there are unjustified premium increases." Not only representatives of labor, industry and government, but medicine itself is becoming concerned.

The Wisconsin Physicians Service, Blue Shield in Wisconsin, which is actually the state society itself in Wisconsin, and not a separate corporation, recently in its own state journal said this: "For while most people will have implicit confidence in a health insurance program approved by the medical profession, there is also, always the possibility that some may think that the doctor's plan is designed primarily to benefit the doctor, rather than the subscriber. Subscribers to Blue Shield and the insured of insurance companies expect to pay reasonable rates for the benefits supported by their policies, but if they are also to be called upon to pay for unnecessary hospitalization, unnecessary procedures and inefficiency, they will consider the rates unreasonable. And if because they have followed the advice of the medical profession and simply because they have insurance, a physician's charges are increased, they will consider the whole proposition unfair." This is especially true when the Blue Shield subscriber of a service plan is charged fees over and above those established by the physicians themselves.

There are men among you, as there are among every group of this type before which I am asked to speak, who take for granted the benefits of Blue Shield and insurance, who regard it as a collection agency for them, and who do nothing to further its cause, who quarrel about its limitations, and even question the need for its existence. These men have a perfect right to their opinions, and their attitudes. In our society, thank the Lord, an individual citizen has a perfect right to be dead wrong. Dr. Elmer Hess, the immediate past president of the American Medical Association, at Seattle last November a year ago, said, "Today's professional freedom to be a private practitioner of medicine instead of a slave of government is due solely to Blue Shield, the physician's answer to socialized medicine." Dr. Hess continued, "Since we have accepted the insurance principle, many patients who previously would be non-paying patients have had their bills at least partially paid. I am rather intolerant of the physician who is not a participating physician in Blue Shield, who in the defense of his attitude, says with a loud voice, 'nobody is going to tell me what to charge.'"

Indemnity Insurance

In addition to Blue Shield and Blue Cross, the profession has endorsed and relied upon indemnity insurance as at least a part of its answer in financing health care. There are as many, if not more, of our people in the country who have purchased indemnity health insurance as have purchased Blue Cross and Blue Shield. There are no overwhelming reasons why indemnity insurance could not adequately serve the medical profession as part of its answer in this field. The unfortunate fact is that in the main, it does not serve medicine, and unless some drastic revisions in viewpoints and practices are brought about, it probably never will. Practices in underwriting indemnity insurance could become one of your greatest problems, and this is so for two obvious reasons. (I wish to make it clear that I am not criticizing the insurance industry. These practices are inherent in the business of insurance and could be modified only by a complete understanding and a co-operation between medicine and insurance. I am only talking about what exists and I do not contend that insurance is dishonorable or conducts itself improperly.)

First, the profit motive, which is the primary reason for investors or members of insurance companies, tends in health insurance, as in all other lines of insurance, to eliminate the poor or substandard risks from acceptance by the carrier. In competing among themselves, as well as with Blue Cross and Blue Shield Plans, the insurance companies have employed a standard practice of insurance underwriting, what is termed experience rating or merit rating, by which rates of members of a particular group are based on that group's own utilization of benefits, its own experience. There is considerable doubt that there is really any distinction between individuals as health risks, regardless of in what group they may be employed. There may be some differentials, justified for expense factors, having to do with billing and collecting, accounting, and so on. There are a number of different applications of the experience rating or merit rating principle, but the results over-all are identical. Reduction in rates, the cost of insurance, which gives advantage to the preferred or so-called "cream risk" can have had only the effect of increasing the cost compared to the total average to the poorer class of risks. The ultimate end of this practice can be rates for insurance that are priced so high that most people will not carry insurance. When the price of insurance is too high for some people and we have many people not carrying it, they will clamor for relief, and the only place they clamor is to their legislators. There is still a Wagner-Murray-Dingell Bill in the Congress.

Second, the failure of insurance to answer socioeconomic problems involving most of our population has been demonstrated in other lines of insurance. An example, and not the only one, is Workmen's Compensation Insurance, where the unwillingness of insurance carriers to expose their funds to substandard or high risk classifications has brought about in many states the establishment of monopolistic compensation funds operated by the state. Other examples are assigned risk pools, which, by law, require the participation of unwilling insurance carriers to provide coverage for poor risks, the state regulation of rates, and even in many states regulations of charges by physicians for services in compensation injury cases.

In no other field of insurance are so many of our individual citizens affected as in health insurance. Every citizen is concerned with the cost of health. Even Harlow C. Curtice, the president of General Motors, complained that when his wife was stricken with an abdominal difficulty, he was charged $900 for a rather serious and difficult operation. One man, H. C. Curtice, can affect

medicine's public relations in the same way as Walter Reuther or George Meaney or other labor leaders. Probably no one man controls as many dollars of Blue Cross and Blue Shield subscriber dues as does Harlow C. Curtice. If he wants to speak in opposition to Blue Cross and Blue Shield in favor of some other method of providing health care for the employees of General Motors and their families, which add up to almost a million people, we may lose General Motors next year in the bargaining between General Motors and the union. If so, we will also lose Ford, Chrysler and 700 other corporations in the state of Michigan that are now enrolled in Blue Cross and Blue Shield.

As General Motors, Ford or Chrysler goes, so goes United Automobile workers. We will lose them not only in Michigan, where they comprise about 3 million of our population in the state and about one half of the 3.6 million people who are enrolled in the Blue Cross and Blue Shield in Michigan, we will also lose them in Florida, California and Washington, and every other state in the Union. A pattern will be set, and that pattern will spill over into the other industries, steel, coal and the rest of them. Blue Shield in Michigan will probably shortly thereafter, and I do not mean a couple of months, be out of business if we lose those groups. And we will lose them because we have failed to do what the public thinks must be done in this field, or because the commercial insurance companies will cut the rates for these cream risks, which up until now, we have been able to sell on the principle of community rating. —the same rate for everyone for the same contract.

We have attempted to find answers for the aged people. In Michigan, Blue Shield is carrying all the retirees in all of the groups which have formal retirement programs. On the average, these people cost us about four and one-half times more in benefits or utilization than the people in the lower ages. To make up this four and one-half times, we have to charge the younger people in these groups enough to carry the old people in the over-all average. If commercial insurance companies are going to fail to cover these older people, and are going to give lower rates to our groups because they do not cover them, we are going to have to quit because we will then have failed to do the job which we set out to do and that was to make good health insurance available to all of the people who want to buy it. The service benefit principle in Blue Shield has often and still does decide the buyer in favor of Blue Shield in competition with indemnity insurance.

Other Threats to Blue Shield and Blue Cross

In the last few years, in order to find some means of competing with Blue Shield and Blue Cross, the commercial companies have developed a completely new idea, which they call Major Medical Insurance Coverage. It has considerable appeal and has considerable merit as it was originally intended as a supplement to good basic health insurance, such as Blue Cross and Blue Shield—particularly for those people who might be called upon, as was Harlow Curtice, to pay bills that are considerably above the average. In order to defeat the competitive advantage of service benefits, however, these commercial insurance companies have now reduced the deductibles and co-insurance features which were of considerable amount in their original package. They are down to such low amounts that they are now practically providing basic coverage. Today, we are seeing Major Medical Insurance, with as low as $25 deductibles, sold in aggregate coverage amounts of up to $25,000. It has a terrific appeal and it is going to cut into Blue Cross and Blue Shield, unless we can broaden the scope of our benefits to provide for the very expensive and unusual and the long stay cases in hospitals.

The big danger in Major Medical, because of its unlimited allocation of large aggregate sums for medical and hospital services, is in the lack of control over charges made by the physicians and the hospitals to these assureds. It is not that the physicians are going to make exorbitant charges, although there is considerable documentation of some of that. It is easy to spot the exorbitant charge and deal with it, such as the $3,500 that was charged the $5,000 a year employee of Ford, in Los Angeles, for a gallbladder operation. The Aetna Insurance Company, which carries that risk, went to the local county mediation committee and got an adjustment on it. It is not that that bothers us. It is the very gradual, almost unconscious increase in all phases which does nothing but increase the cost of medical care out of proportion to other increases so that eventually the cost of health care becomes such that only a few people can afford it, and the others will call upon the government to provide what they think they need. I am not going into detail about the many other threats—we

consider them threats—such as the closed panel practice groups, Health Insurance Plan of New York, Kaiser Permanente and Ross Loos type of coverage. These are almost all closed panel practice groups and some of them on the prepayment principle, such as Health Insurance Plan of New York City and Permanente in California. They all have varying arrangements on paying physicians on a salary or per capitation basis and they limit the choice of physician. Some of these are showing healthy growth and a degree of acceptance by members of the profession which is alarming, in that these physicians seem to prefer the security of salaries to the competitive practice of medicine.

There are plenty of examples of government intervention into the field of paying for the health care of citizens, and the most recent example, of course, as you can understand without detailed description of it, is Medicare. While we are on this question of Medicare, because it is a controversial one in Medicine, I do not think that there is over one physician in a thousand in this country who knows how you got where you are in Medicare. It is easy to sit back and criticize the fact that this is a service program in which you are obliged to accept the fees if you treat these people, these assumed wards of government. I would like to state I was one of the three people representing organized medicine in the conferences and discussions and battles in Washington on the Medicare Bill. This came about, not as a result of the introduction of a bill in the last session of the Congress; it came about as a result of six years of hard work by many doctors of the American Medical Association. It was not a question of whether we were going to build more government hospitals and draft more doctors into the armed services to take care of these dependents, because they were going to be taken care of. We did not get everything we wanted in the Medicare Bill. We got the best possible compromise, however, and Medicine right now, by ill-considered action, can wreck the best deal that you could possibly have gotten as regards the dependents of these service men, by denying them service benefits under Medicare. The only possible alternative to that will be the government back in the construction of hospitals and the drafting of doctors. It did not happen overnight; it took six years to get to this point. I am convinced that only about one doctor in a thousand knew that you just made the best deal you could make and that the alternative was much worse.

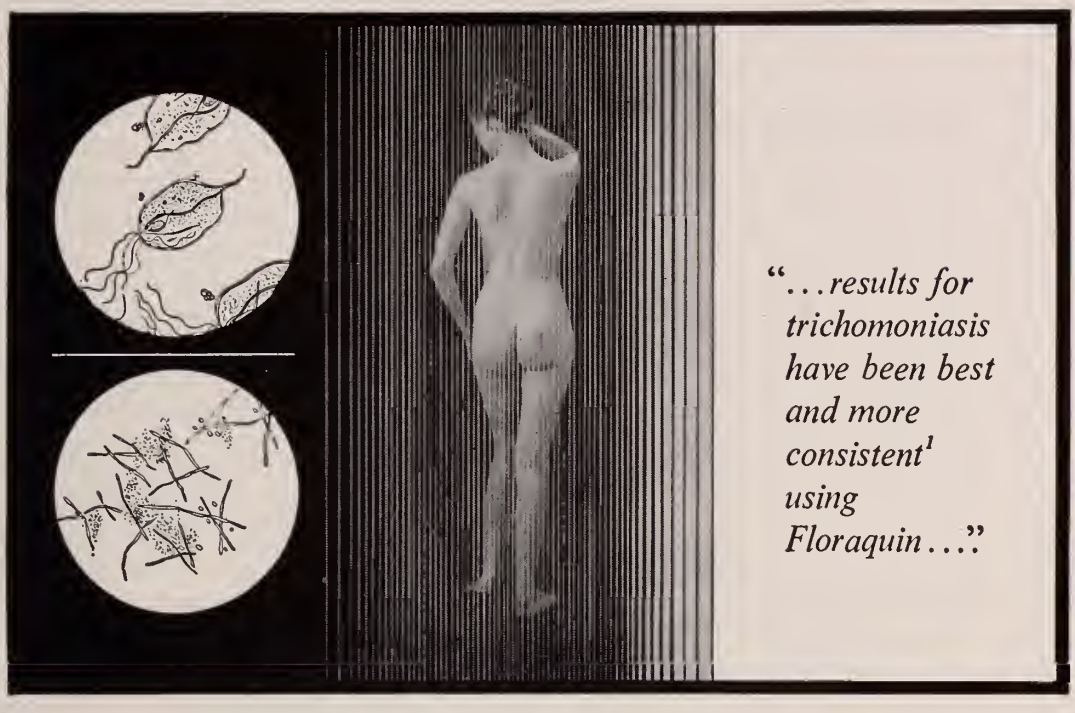
Medicine's Weaknesses

Perhaps the greatest help I could be to the Florida Medical Association would be to point out what I consider your greatest weakness in this field of health economics. The first point in this description of your weakness would be the complacency with which most doctors view the situation—the expressed "go away and leave me alone" attitude. I believe that Medicine is just not equipped, up to this point, to deal adequately with its problems in the financing, or the economics, of health care. Most doctors, because of complacency or lack of time to devote to the economic side of medicine, do not possess the knowledge necessary to evaluate the case. Medicine has not the means of communication necessary to provide the necessary intelligence to its membership, and if it had, it still does not have the discipline or the cohesion within its ranks to present a united front or to take the united action necessary if its policies are to prevail. Medicine individually and collectively must acquire the knowledge and the intelligence in this vital area, consider its position, make decisions and act. This is a large order, time-consuming and often frustrating. If the job is to be done, Medicine must be prepared to delegate to its able and available members not only the responsibility, but as well, the authority, and it must have discipline within itself.

If the voluntary method is to be your answer, as you contend it is, you have the responsibility to see that it works, and if Blue Shield is not yours, you must see that it is made so. If it is not what you want it to be, you must change it. If you are convinced that Medicine needs Blue Shield, support it. If you are convinced it does not need it, kill it now because any further promise to the public on which you fail to deliver will cost you more than no promise at all.

It is impossible for any plan to satisfy all the varied and sometimes opposed views and interests of all the specialties and the branch societies in Medicine. There is only one banner about which all doctors can rally. It must consider all the varied interests, evaluate all the special problems, compromise, agree and decide, direct and support united action on behalf of all the profession. Dr. Austin Smith, editor of the Journal of the American Medical Association, in Lansing, Mich., just a few months ago pleaded with the doctors to join hands in a united effort, a united front to prevent the catastrophy that has overwhelmed

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1. Pitt, M. B.: Leukorrhea. Causes and Management, J. M. A. Alabama *25*:182 (Feb.) 1956.
2. Parker, R. T.; Jones, C. P., and Thomas, W. L.: Pruritus Vulvae, North Carolina M. J. *16*:570 (Dec.) 1955.

SEARLE

the profession in almost every other country in the world. I mentioned earlier that Blue Shield was built around the principles of freedom of choice and I do not mean by that that I believe your choice is unrestricted. I believe the choice in this case does not include the privilege of ignoring the pressures upon you. You will decide between just two alternatives: (1) Let others advance and impose upon you their proposals, which will probably be abhorrent to you, or (2) make Blue Shield an adequate, functioning, reliable program, providing for the cost of health care under your sponsorship and control, where I am certain control must be.

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STATE NEWS ITEMS

The Florida Society of Dermatology has scheduled its annual meeting for April 19-20 in the Balmoral Hotel, Bal Harbour on Miami Beach, according to announcement by Dr. Kenneth J. Weiler, of St. Petersburg, secretary of the Society. The Southeastern Dermatological Association is also meeting in the Balmoral Hotel at the same time. The Florida Society of Dermatology was formerly the Florida Society of Dermatology and Syphilology.

The annual meeting of the Gulf Coast Clinical Society will be held in Pensacola, Thursday and Friday, October 23-24, 1958. Dr. Lee Sharp, of Pensacola, is president, and Dr. John J. Baehr Jr., also of Pensacola is secretary-treasurer.

Dr. Peter F. Ragan III has been appointed Chairman of the Department of Psychiatry at the College of Medicine of the University of Florida in Gainesville. Dr. Ragan formerly served as Assistant Professor of Psychiatry at Cornell University Medical College and Assistant Attending Psychiatrist at New York Hospital.

Dr. Louis M. Orr of Orlando, who is serving as vice speaker of the House of Delegates of the American Medical Association, will be featured speaker at the fourth annual Senior Day Program on April 21 in Louisville, Ky. The event is sponsored by the University of Louisville School of Medicine, the Kentucky State Medical Association and the Jefferson County Medical Society.

The Tenth Annual Scientific Assembly of the American Academy of General Practice is being held March 24-27 in the Memorial Auditorium at Dallas, Texas. The program features 35 prominent physicians as speakers, 90 scientific and 300 technical exhibits.

Dr. DeWitt C. Daughtry of Miami, president of the Florida Tuberculosis and Health Association, has announced the availability of a limited number of grants for medical research in tuberculosis and related fields. Grants are open to personnel attached to an approved hospital, medical center or university. Applications should be submitted to the Chairman, Medical and Social Research Committee, Florida Tuberculosis and Health Association, P. O. Box 4785, Jacksonville.

Drs. Henry J. Babers Jr. and J. Maxey Dell Jr. of Gainesville participated in the symposium which was part of a Cancer Institute sponsored recently for nurses at the J. Hillis Miller Health Center in Gainesville.

A review course in Surgical Pathology principally designed for physicians preparing for examination by the American Board of Surgery will be offered at the Baptist Memorial Hospital in Jacksonville beginning April 2. The course will be conducted by Drs. Alvan G. Foraker and Curtis M. Phillips of Jacksonville. Interested physicians are requested to contact Dr. Foraker, Baptist Memorial Hospital, Jacksonville, for information.

Dr. Henry G. Morton of Sarasota has been named Doctor of the Year by the Sarasota County Medical Society. He is president of the Florida Chapter of the American Academy of Pediatrics and has been practicing in Sarasota for about 15 years.

Dr. Thomas H. Lipscomb of Jacksonville has been appointed chairman of the State Air Pollution Control Commission.

The Third International Congress of Allergy is being held in Paris, France, October 19-26, 1958. It is sponsored by the International Association of Allergollogy and the French Allergy Association. For information regarding the program, physicians are requested to contact Dr. Samuel M. Feinberg, 303 East Chicago Ave., Chicago, Ill.

The Fourth Annual Surgery, Radiology, Pathology Symposium sponsored by the Division of Postgraduate Medicine of the University of Oklahoma Medical Center has been scheduled for March 14-15. Information is available from the Division of Postgraduate Education, University of Oklahoma School of Medicine, Oklahoma City, Okla.

Dr. James C. Rinaman of St. Cloud was principal speaker at a recent meeting of the Parent-Teachers' Association there. His topic was "School and Health Examinations."

The Fourteenth Congress of the American College of Allergists and the Graduate Instructional Course in Allergy will be held in Atlantic City, N. J., April 20-25. The headquarters hotel is the Shelburne.

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Dr. Purdue L. Gould of Lakeland discussed "Diagnosis and Care of Brain Tumors" at the January meeting of members of District No. 12, Florida Nurses Association, held at Morrell Memorial Hospital in Lakeland.

Dr. Millard B. White of Sarasota was principal speaker at a recent meeting of the Venice-Nokomis Rotary Club.

Dr. John J. Farrell of Miami served as a member of the panel which discussed the complications of abdominal surgery at the recent sectional meeting of the American College of Surgeons held at Jackson, Miss.

Dr. George W. Karelas of Newberry discussed "Some Problems Pertaining to Older People" at a recent meeting of the Division of Books at the Twentieth Century Club held in Gainesville.

The Sixth Annual Interim Scientific Meeting of Phi Lambda Kappa medical fraternity will be held at the Deauville Hotel, Miami Beach, April 13-20. The program, arranged primarily for the general practitioner, features papers and symposia by specialists in their fields. Advance registration is being handled by Dr. Samuel L. Lemel, 1030 Euclid Ave., Cleveland 15, Ohio.

The Thirty-Sixth Annual Scientific and Clinical Session of the American Congress of Physical Medicine and Rehabilitation will be held August 24-29 at the Bellevue Stratford Hotel, Philadelphia. Information may be obtained from Miss Dorothea C. Augustin, executive secretary of the Congress, 30 North Michigan Ave., Chicago 2, Ill.

Dr. Leonard G. Rowntree of Miami Beach has been awarded the honorary degree of Doctor of Letters by the University of Miami for his "great contributions to the progress of medicine and his significant role in the founding of the University of Miami School of Medicine."

Dr. William C. Roberts of Panama City, President of the Florida Medical Association, was among the group of citizens of that city honored recently by the First Friday Club of the Chamber of Commerce.

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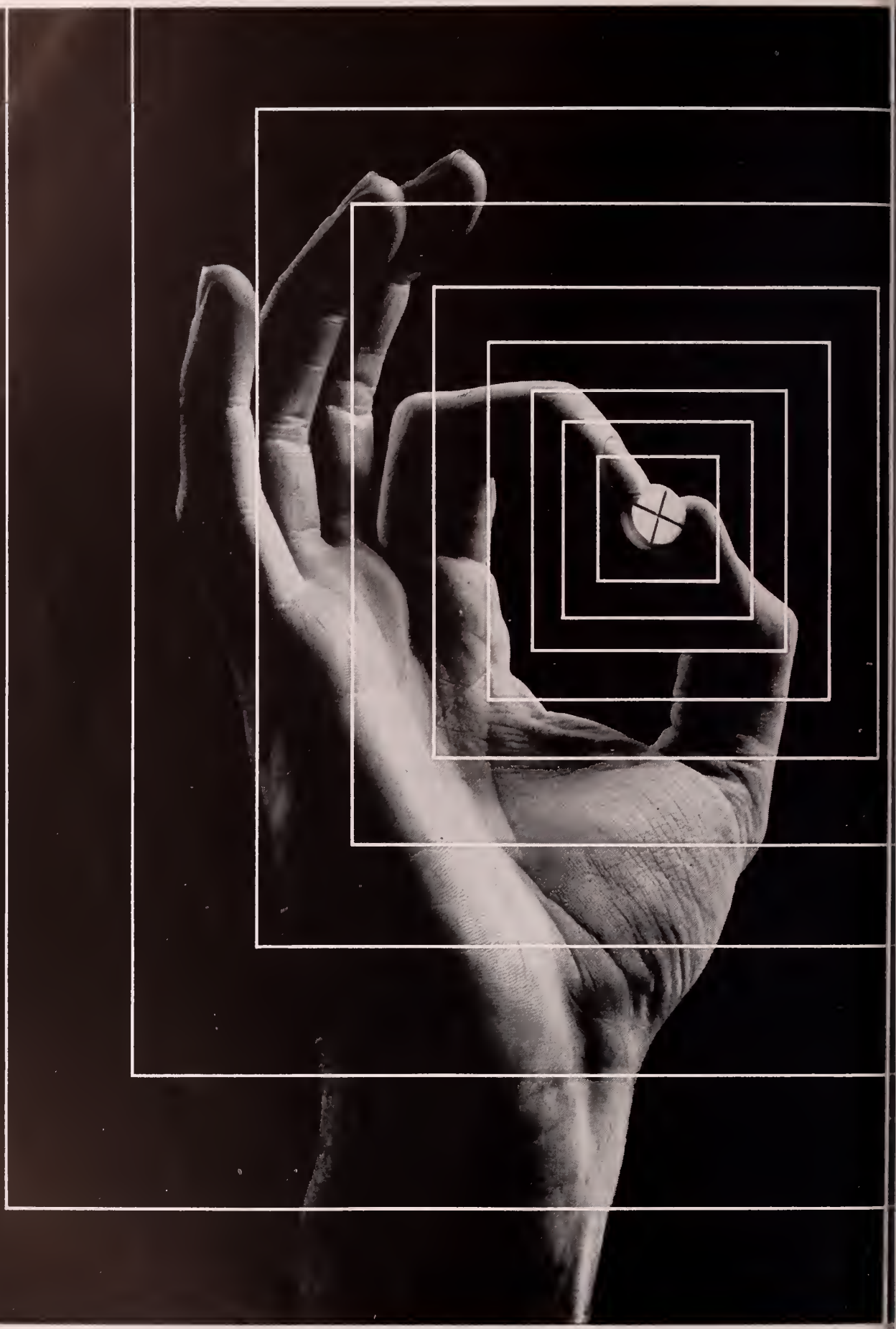
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1. Nichols, R. L. and Finland, M.: *J. Clin. Med.* 49:410, 1957.

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COMPONENT SOCIETY NOTES

Bay

Dr. Sidney E. Daffin has been elected president of the Bay County Medical Society. Dr. James D. Nixon has been chosen vice president, and Dr. Henry C. Smallwood secretary. All the officers are from Panama City.

Brevard

Dr. William H. Eyster, of Indialantic, presented a comprehensive and interesting discussion of the "Office Management of Common Skin Diseases" at the January meeting of the Brevard County Medical Society. The meeting was held in the Rockledge Clinic at Rockledge.

Collier

Dr. David R. Millard Jr., of Miami, was principal speaker on the program for the January meeting of the Collier County Medical Society held at the Naples Community Hospital.

DeSoto-Hardee-Highlands-Glades

Newly elected officers of the DeSoto-Hardee-Highlands-Glades County Medical Society are Dr. Charles H. Kirkpatrick, president; Dr. Harold S. Agnew, vice president, and Dr. Gordon H. McSwain, secretary-treasurer. All are from Arcadia.

Duval

Dr. Edward R. Woodward, of Gainesville, Professor of Surgery and head of the Department of Surgery at the College of Medicine, University of Florida, discussed "Recent Studies on the Antrum of the Stomach" at the February meeting of the Duval County Medical Society.

Indian River

Dr. Enoch J. Vann who served the Indian River County Medical Society as secretary last year has been elected president for 1958. Chosen to serve with Dr. Vann are Dr. B. Bowman Guerin as vice president, and Dr. Charles F. Rattray Jr. as secretary. The officers are from Vero Beach.

Lake

Dr. William Chew, of Orlando, presented an excellent address on "Diagnostic Procedures in Chest Pathology" at the December meeting of the Lake County Medical Society. The meeting was held at Howey-in-the-Hills.



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Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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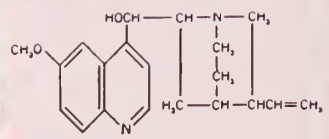
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"It has a high degree of clinical safety. . . It is considered to be the preferred antimalarial drug for treatment of disorders of connective tissue, because of the low incidence of gastrointestinal distress as compared to that with chloroquine phosphate."[1]

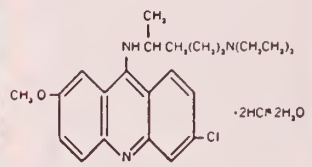
". . . Plaquenil is decidedly less toxic and better tolerated by the average patient, even in high dosage, than is chloroquine."[2]

". . . the least toxic of its class . . ."[3]

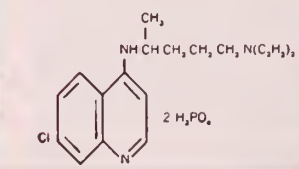
QUININE



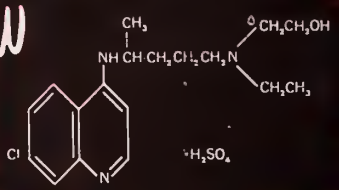
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ARALEN® PHOSPHATE



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Plaquenil® SULFATE

Remarkably effective in RHEUMATOID ARTHRITIS

SIDE EFFECTS MARKEDLY REDUCED

DOSE: **Initial** — 400 to 600 mg. (2 or 3 tablets) Plaquenil sulfate daily.
Maintenance — 200 to 400 mg. (1 or 2 tablets) daily.

SUPPLIED: Tablets of 200 mg., bottles of 100.

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Winthrop LABORATORIES NEW YORK 18, N.Y.

RENCES.
cherbel, A. L., Schuchter, S. L., and Harrison, J. W. *Cleveland Clin. Quart.* 24: 98, Apr. 1957

Atabrine (brand of quinacrine) Aralen (brand of chlo and Plaquenil (brand of hydroxych

For the January meeting, Dr. James L. Campbell Jr., of Orlando, discussed the problem and indications for radical perineal prostatectomy. He presented a film to illustrate his address.

Lee-Charlotte-Hendry

Dr. Gustave F. Bieber has been elected president of the Lee-Charlotte-Hendry County Medical Society. Dr. James L. Bradley has been chosen vice president, and Dr. William M. Taylor secretary-treasurer. All are from Ft. Myers.

Leon-Gadsden-Liberty-Wakulla-Jefferson

The regular quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held the middle of January in the W. T. Edwards Hospital at Tallahassee. Dr. George S. Palmer, president of the Society, presided. Speakers included Dr. Thomas J. Brooks, Assistant Dean of Medicine at the University of Mississippi Medical Center in Jackson, and Dr. Robert G. Ellison, Assistant Professor of Surgery at the Medical College of Georgia at Augusta.

Madison

Dr. Wilmer J. Coggins, of Madison, has begun serving as president of the Madison County Medical Society. Dr. Julian M. DuRant, also of Madison, is serving with Dr. Coggins as secretary-treasurer.

Marion

The Marion County Medical Society held its annual seafood supper January 14 at the Magnolia Lodge in Crystal River. Dr. Beverly Douglas, of Nashville, Tenn., was a guest.

Pinellas

Dr. H. Phillip Hampton, of Tampa, was principal speaker at the January meeting of the Pinellas County Medical Society. His topic was "Remarks on Welfareism." Dr. John M. Thompson, of St. Petersburg, discussed "Recent Advances in Neurological Surgery" at the Society's February meeting.

Putnam

Dr. Bennie J. Massey has been elected president of the Putnam County Medical Society. Drs. Lawrence G. Hebel and Fairfax E. Montague are to serve with Dr. Massey, Dr. Hebel as chairman of the Society, and Dr. Montague as secretary-treasurer. All are from Palatka.

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St. Johns

Dr. Thomas L. Glennon, of Green Cove Springs, has been elected president of the St. Johns County Medical Society. Dr. William J. Gibson, of St. Augustine, who served as secretary of the Society last year, has been chosen vice president, Dr. Walter Weigel, of St. Augustine, secretary, and Dr. S. Raymond Cafaro, also of St. Augustine, treasurer.

St. Lucie-Okeechobee-Martin

Dr. Howard C. McDermid has begun serving as president of the St. Lucie-Okeechobee-Martin County Medical Society. Dr. McDermid was vice president last year. Drs. Robert F. Meeko and Maltby F. Watkins are serving with Dr. McDermid, Dr. Meeko as president-elect, and Dr. Watkins as secretary-treasurer. All are from Fort Pierce.

Taylor

Dr. John A. Dyal Jr. has been elected president of the Taylor County Medical Society. Dr. John H. Parker Jr. has been chosen vice president, and Dr. Charles R. Wiley secretary.

Volusia

Dr. William C. Roberts of Panama City, President of the Florida Medical Association, was principal speaker on the program of the February meeting of the Volusia County Medical Society.

Walton-Okaloosa-Santa Rosa

Dr. Howard A. Parker, of Valparaiso, formerly secretary-treasurer of the Walton-Okaloosa-Santa Rosa County Medical Society, has been elected president. Dr. Frederic E. Caldwell, of Fort Walton Beach, has been chosen vice president, and Dr. Eric F. Geiger, of Milton, has been elected secretary-treasurer to succeed Dr. Parker.

MARRIAGES AND DEATHS

Marriage

Dr. Donald M. Bryan, of St. Petersburg, and Dr. Laurette Adelaide Martin, of Miami, were married January 5, 1958, at Coral Gables.

Deaths — Members

Buford, Coleman, G., West Palm Beach	Dec. 23, 1957
Conklin, Raymond C., Mount Dora	Nov. 19, 1957
Johnston, Walter B., Winter Park	Nov. 19, 1957
Moore, John T., Tampa	Jan. 11, 1958

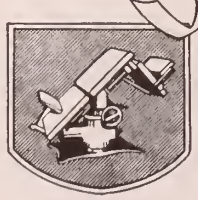
Deaths — Other Doctors

Burns, Joseph P., Lake City	Oct. 28, 1957
Krans, DeHart, Tallahassee	Oct. 13, 1957
Martinson, Martin M., Orlando	Oct. 3, 1957

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TAKES EXPERIENCE

KNOW WHAT — KNOW HOW

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have a combined total of 65 years experience —
plus a large stock and repair department.



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SUPPLY COMPANY

AMERICAN SURGICAL TRADE ASSOCIATION ASTA

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If
Monilial overgrowth
is a factor

Achrostatin* V

TETRACYCLINE (PHOSPHATE-BUFFERED) AND NYSTATIN

Combines Achromycin V with Nystatin

SUPPLIED:

CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin. ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

DOSAGE:

Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of Achrostatin V per day, equivalent to 1 Gm. of Achromycin V.

Achrostatin V combines Achromycin† V ... the new rapid-acting oral form of Achromycin† Tetracycline ... noted for its outstanding effectiveness against more than 50 different infections ... and Nystatin ... the antifungal specific. Achrostatin V provides particularly effective therapy for those patients prone to monilial overgrowth during a protracted course of antibiotic treatment.

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'DIURIL'

(CHLOROTHIAZIDE)

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EDEMA



Start therapy with one or two 500 mg. tablets of 'DIURIL' once or twice a day.

BENEFITS:

- The only orally effective nonmercurial agent with diuretic activity equivalent to that of the parenteral mercurials.
- Excellent for initiating diuresis and maintaining the edema-free state for prolonged periods.
- Promotes balanced excretion of sodium and chloride—without acidosis.

Any indication for diuresis is an indication for 'DIURIL':

Congestive heart failure of all degrees of severity; premenstrual syndrome (edema); edema and toxemia of pregnancy; renal edema—nephrosis; nephritis; cirrhosis with ascites; drug-induced edema. May be of value to relieve fluid retention complicating obesity.

SUPPLIED: 250 mg. and 500 mg. scored tablets 'DIURIL' (chlorothiazide); bottles of 100 and 1,000.

'DIURIL' and 'INVERSINE' are trade-marks of Merck & Co., Inc.

MSD

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HYPERTENSION

1 INITIATE 'DIURIL' THERAPY

'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 ADJUST DOSAGE OF OTHER AGENTS

The dosage of other antihypertensive medication (reserpine, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be *immediately* reduced by 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 ADJUST DOSAGE OF ALL MEDICATION

The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.



BENEFITS:

- improves and simplifies the management of hypertension
- markedly enhances the effects of antihypertensive agents
- reduces dosage requirements for other antihypertensive agents—often below the level of distressing side effects
- smooths out blood pressure fluctuations

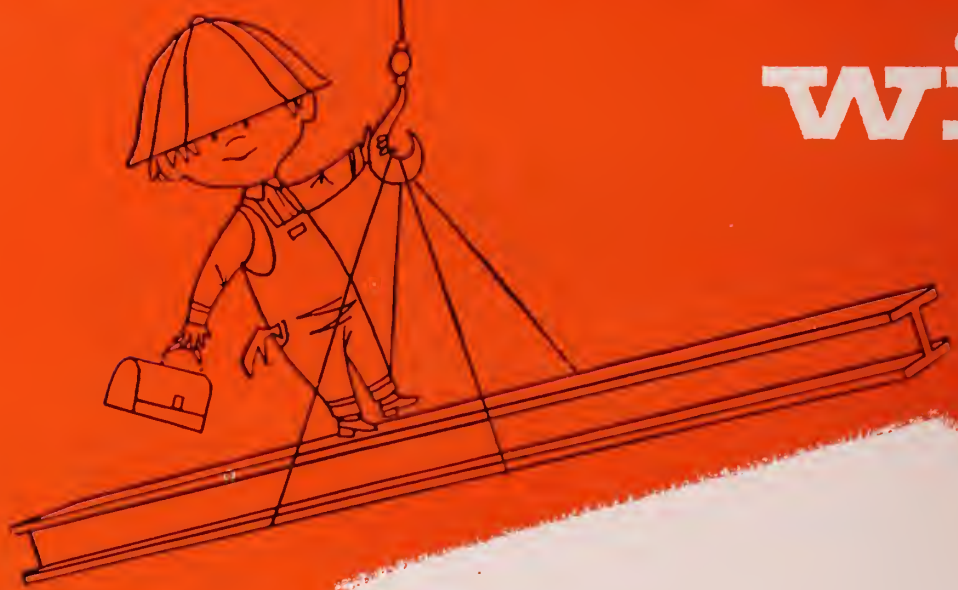
INDICATIONS: management of hypertension

Smooth, more trouble-free management of hypertension with 'DIURIL'

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CORRECTS IRON DEFICIENCY AS IT STIMULATES APPETITE

- Offers appetite stimulating Vitamins B_1, B_6, B_{12} and protein upgrading l-Lysine, fortified with a readily absorbed, well tolerated form of iron.
- Delicious cherry base designed to appeal to all patients.

PARTICULARLY FOR CHILDREN

Helps young appetites keep pace with the increased nutritiona demands of childhood while supplying adequate amounts o essential iron.

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LYSINE-VITAMINS

SYRUP



Provides the following percentages of Minimum Daily Requirements per teaspoonful:

	Child under 6	Child over 6	Adult
B_1	2000%	1333%	1000%
Iron	400%	300%	300%

FORMULA

EACH TEASPOONFUL (5 cc.) CONTAINS

l-Lysine HCl	300 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine Mononitrate (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Alcohol	0.75%

Average dosage is one teaspoonful daily. Available in bottles of 4 fl. oz.

*REG. U. S. PAT. OFF.

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Lederle



in peptic ulcer

Results with "... antacid therapy with DAA are essentially the same as ... with potent anticholinergic drugs."

Alglyn®

Dihydroxy aluminum aminoacetate, N.N.R.

In recent years, a number of new synthetic anticholinergic drugs with numerous and varying side effects have been investigated for treatment of peptic ulcer. However, a double-blind study conducted recently by Cayer et al suggests that the use of such anticholinergic drugs is seldom necessary. The authors concluded that "The percentage of 'good to excellent' results obtained in patients on continuous long-term antacid therapy with DAA (74%) is essentially the same as that previously noted in ulcer patients treated under similar conditions with potent anticholinergic drugs alone."

The authors' choice of dihydroxy aluminum aminoacetate (DAA) was based on the fact that "the tablet form of DAA (is) more active than a variety of straight aluminum hydroxide magmas." They further commented that "Because of the convenience of tablet medication as compared with the liquid gel—a convenience which in the use of other tablets is gained at the expense of therapeutic effectiveness—dihydroxy aluminum aminoacetate was used exclusively."

ALGLYN (dihydroxy aluminum aminoacetate) Tablets are supplied in bottles of 100 tablets (0.5 Gm. per tablet).

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- ARTHRITIC DISORDERS
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KENACORT

- far less gastrointestinal distress
- safe to use in asthma with associated cardiac disease; no sodium and water retention
- does not produce secondary hypertension—low salt diet not necessary
- no unnatural psychic stimulation
- often works when other glucocorticoids have failed
- and on a lower daily dosage range

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"KENACORT" IS A SQUIBB TRADEMARK

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Each pill is
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Physiologically Standardized
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Clinical samples sent to physicians upon request.

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WANTED: General Practitioner qualified to do surgery or surgeon willing to do general practice in small town with excellent hospital. Salary or percentage to start; partnership after six months. Write 69-254, P.O. Box 2411, Jacksonville, Fla.

BRAND NEW AIR CONDITIONED AND HEATED MEDICAL BUILDING in fast growing North Miami has three openings. Prefer Board-certified (or eligible) internist, ophthalmologist, otolaryngologist, dermatologist, or laboratory to complement present occupants: pediatrician, surgeon, orthopedist, obstetrician. All independent. See it at 1545 N.E. 123rd Street and phone PL 4-2744.

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WANTED: General Practitioner or Pediatrician to share fully equipped office with M.D. in N.W. Miami; part or full time. Florida license necessary. Excellent opportunity. Write 69-258, P.O. Box 2411, Jacksonville, Fla.

POSITION WANTED: General Surgeon, Board eligible, desires location or position in small Florida city. Write 69-259, P.O. Box 2411, Jacksonville, Fla.

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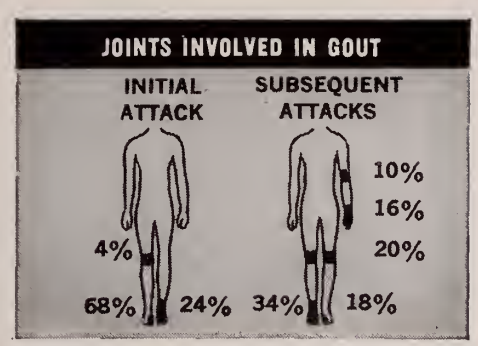
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PEDIATRICIAN: Completing training in July 1958. University trained. Board eligible in Pediatrics. Florida license. Desires group practice or association with one or more pediatricians. Write 69-261, P.O. Box 2411, Jacksonville, Fla.

POSITION WANTED: In Ophthalmology or EENT by Georgian. Florida license. Board eligible in Ophthalmology. 3 years in EENT practice. Write 69-262, P.O. Box 2411, Jacksonville, Fla.

POSITION WANTED: Board eligible Internist. Completing residency in June 1958. Will consider some General Practice to begin. Write 69-263, P.O. Box 2411, Jacksonville, Fla.

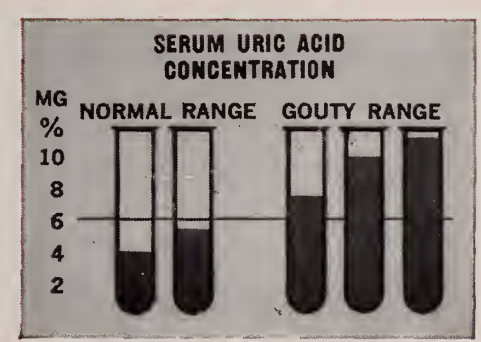
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1. Recurrent joint pain followed by long periods of complete remission. *(Percentages refer to incidence.)*



2. Enlargement of bursae such as in this case involving the olecranon bursa.



3. Elevated serum uric acid levels.



4. Colchicine test: full dose (0.5 mg.) every 1 to 2 hours until pain is relieved or nausea, vomiting or diarrhea occur. The test requires usually 8 to 16 doses. Pain relief is highly indicative of gout.

FROM THESE FINDINGS...SUSPECT GOUT:

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PROBENECID

A SPECIFIC FOR GOUT

Once findings point to gout, long-term management can be started with BENEMID. This effective uricosuric agent has these unique benefits:

- Urinary excretion of uric acid is approximately doubled.
- Serum uric acid levels are reduced.
- Uric acid deposits (tophi) in tissues are mobilized.
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- Fewer attacks and severity is reduced.

RECOMMENDED DOSAGE: 0.25 Gm. (½ tablet) twice daily for one week followed by 1 Gm. (2 tablets) daily in divided doses.

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NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Ballard, William C., St. Petersburg
Bunch, Rob R., St. Petersburg
Clayton, Malcolm D. Jr., Tampa
Gould, Purdue L., Lakeland
Hamilton, John M., St. Petersburg
Hartman, Howard E., Sarasota
Johnson, Walter H., Largo
Kaszuba, Alexander, St. Petersburg
Levy, Sidney W., Quincy
Magill, John C., St. Petersburg
Miller, Helen K., Tampa
Montague, Fairfax E., Palatka
Myerson, Samuel, St. Petersburg
Orr, Alva D., Fort Pierce
Penick, Richard Q., Jensen Beach
Rattray, Charles F. Jr., Vero Beach
Sherman, Arthur G., St. Petersburg
Siek, H. Gerard Jr., Clearwater
Smallwood, Henry C., Panama City
Tagliarini, Frank P., Tampa
Tanner, Terry F., St. Petersburg
vanBoven, John III, Palm Beach
Weigel, Walter W., St. Augustine

OBITUARIES

John Singer McEwan

Dr. John Singer McEwan of Orlando died on Sept. 26, 1957, at Orange Memorial Hospital where for many years he was chief of the surgical service. He had been hospitalized there for nearly two years with a heart ailment. He was 80 years of age.

Dr. McEwan was born in Cooperstown, N.Y., on Sept. 4, 1877. His early professional training was in pharmacy and for a time he had a drugstore in Carlsbad, N. Mex. He then attended Northwestern University Medical School in Chicago, where he was awarded the degree of Doctor of Medicine in 1905. His medical fraternity was Phi Beta Pi. After graduation, he served an internship in New York at the New York City Hospital.

In 1906 Dr. McEwan entered the private practice of medicine in Orlando in association with Dr. R. L. Harris, but soon opened his own office, specializing in surgery. For half a cen-

(Continued on page 1018)

NEW *"flavor-timed" dual-action*
CORONARY VASODILATOR

Dilcoron TRADEMARK

ORAL (tablet swallowed whole)
for dependable prophylaxis
SUBLINGUAL-ORAL
for immediate and sustained relief
of **ANGINA PECTORIS**



NITROGLYCERIN—
0.4 mg. (1/150 grain)—acts quickly

CITRUS "FLAVOR-TIMER"—
signals patient when to swallow

PENTAERYTHRITOL TETRANITRATE—
15 mg. (1/4 grain)—prolongs action

For continuing prophylaxis patient swallows the entire Dilcoron tablet.
Average prophylactic dose:
1 tablet four times daily.
Therapeutic dose:
1 tablet held under the tongue until citrus flavor disappears, then swallowed.

Bottles of 100.

Winthrop LABORATORIES NEW YORK 18, N. Y.

a new high in
anti-inflammatory effects
with lower dosage
(averages 1/3 less than
prednisone)

The
Achievements
of

Aristocort®

Triamcinolone LEDERLE

a new low in the collateral
hormonal effects associated
with all previous corticosteroids

- No sodium or water retention
- No potassium loss
- No interference with psychic equilibrium
- Low incidence of peptic ulcer and osteoporosis

Aristocort is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

Lederle

The Achievement in Skin Diseases: In a study of 26 patients with severe dermatoses, ARISTOCORT was proved to have potent anti-inflammatory and antipruritic properties, even at a dosage only ⅔ that of prednisone.[1]... Striking affinity for skin and tremendous potency in controlling skin disease, including 50 cases of psoriasis, of which over 60% were reported as *markedly improved*[2]... absence of serious side effects specifically noted.[1,2,3]

The Achievement in Rheumatoid Arthritis: Impressive therapeutic effect in most cases of a group of 89 patients[4]...6 mg. of ARISTOCORT corresponded in effect to 10 mg. of prednisone daily (in addition, gastric ulcer which developed during prednisone therapy in 2 cases disappeared during ARISTOCORT therapy).[5]

Arist

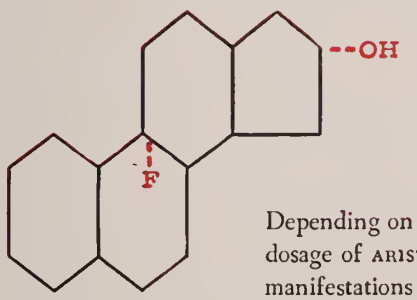
1. Rein, C. R., Fleischmajer, R., and Rosenthal, A. L.: J. A. M. A. *165*:1821, (Dec. 7) 1957.
2. Shelley, W. B., and Pillsbury, D. M.: Personal Communication.
3. Sherwood, A., and Cooke, R. A.: Personal Communication.
4. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957.
5. Hartung, E. F.: Personal Communication.
6. Schwartz, E.: Personal Communication.
7. Sherwood, A., and Cooke, R. A.: J. Allergy 28:97, 1957.
8. Hellman, L., Zumoff, B., Kretshmer, N., and Kramer, B.: Paper presented at Nephrosis Conference, Bethesda, Md., Oct. 26, 1957.
9. Ibid.: Personal Communication.
10. Barach, A. L.: Personal Communication.
11. Segal, M. S.: Personal Communication.
12. Cooke, R. A.: Personal Communication.
13. Dubois, E. L.: Personal Communication.

The Achievement in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.[6]... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.[7]

The Achievement in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.[8,9]... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.[10,11,12]... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.[13]

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Triamcinolone LEDERLE



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.

Lederle LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER NEW YORK

(Continued from page 1014)

tury thereafter he was prominently identified with the professional, civic and social life of the city. He was the local surgeon for the Atlantic Coast Line Railroad for many years, and he served on the Florida Crippled Children's Commission under five governors starting with Gov. Spessard Holland in 1940. He was a charter member of the Orlando Rotary Club and was a Mason with affiliations in Orlando Lodge No. 69, F&AM, Eureka chapter No. 7, RAM, Orlando Council No. 5, R&SM, Olivet Commandery No. 4, and Morocco Shrine Temple. He was a member of the Cathedral Church of St. Luke. Also, he held membership in the Orlando Country Club and the Orlando University Club. For many years he served on the Orlando Utilities Commission, for a time as president, and was also a director in the Gulf Life Insurance Company.

Prior to the entry of the United States into World War I, Dr. McEwan volunteered for the American Ambulance Corps and went to France. He was chief surgeon of a hospital at Juilly, France, behind the front lines at Verdun and was given the rank of major in the French army.

Soon after engaging in the practice of surgery in Orlando, Dr. McEwan recognized the need of a county medical society closer than the one in Tampa, which he attended. He therefore was most active in the formation of the Orange County Medical Society in 1908 and served as its first secretary.

A distinguished member of the Florida Medical Association through the years, Dr. McEwan served as its president in 1925. He held life membership with honorary status at the time of his death and was completing his fiftieth year of membership in the Association.

One of the original diplomates of the American Board of Surgery, this pioneer Florida surgeon was a fellow of the American College of Surgeons and a member of the Southern Surgical Society. In addition, he held membership in the American Medical Association and the Southern Medical Association.

In 1907, Dr. McEwan was married to Roberta Dunn of Sanford, who survives him. Also surviving are three sons, John A. McEwan, O. Beverly McEwan and Robert H. McEwan, all of Orlando, and seven grandchildren. Other survivors include

TAKE A LOOK AT
NEW DIMETANE
THE UNEXCELLED
ANTIHISTAMINE

a brother, Arthur McEwan, of Oneonta, N.Y., and a nephew, Dr. Duncan T. McEwan, of Orlando, who took over his practice when he retired.

Alfred Eugene Cronkite

Dr. Alfred Eugene Cronkite of Fort Lauderdale died of a heart attack while at work at his office on Sept. 27, 1957. He was 45 years of age.

A native of Los Angeles, Dr. Cronkite was born on Sept. 9, 1912. He had his early schooling in the public schools of Los Angeles. He received his Bachelor of Arts degree at Stanford University and was awarded the degree of Doctor of Medicine by the Stanford University School of Medicine in San Francisco in 1938. His medical fraternity was Alpha Kappa. After graduation he served as an instructor and as an Assistant in Anatomy at his alma mater for a year and spent the following year there as a research fellow in the Department of Public Health and Preventive Medicine. After completing an internship in Oakland, Calif., he held successive fellowships in Surgery and Pathology at the Mayo Clinic in Rochester, Minn., for five years. During World War II he served three years aboard a destroyer in the Pacific.

In January 1949, Dr. Cronkite came to Florida to become Broward County's first full time pathologist, serving at the North Broward General Hospital in that capacity until 1956. In December 1951, he became the first Medical Examiner for Broward County, retiring in 1956 because of illness. He established the first blood bank in that county and helped organize the Florida Blood Bank Clearing House; he was a strong supporter of the American Association of Blood Banks. He was also the first to establish a Department of Forensic Pathology in Florida.

Locally, Dr. Cronkite was a Rotarian, a director of the Broward County Chapter of the American Red Cross, a Boy Scout leader, and Director of the Broward County Tumor Clinic. He was particularly interested in the work of the American Cancer Society and was influential in establishing a medical library at North Broward General Hospital. He was affiliated with the Church-by-the-Sea.

(Continued on page 1026)

Dimetane®
(PARABROMDYLAMINE MALEATE)
TABLETS (4 MG.), ELIXIR (2 MG. PER 5 CC.) AND EXTENTABS® (12 MG.) UNEXCELLED POTENCY, UNSURPASSED THERAPEUTIC INDEX AND RELATIVE SAFETY. MINIMUM DROWSINESS AND OTHER SIDE EFFECTS. A. H. ROBINS CO., INC., RICHMOND, VIRGINIA. ETHICAL PHARMACEUTICALS OF MERIT SINCE 1878
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Significant **Robins** research discovery:

A NEW SKELETAL MUSCLE RELAXANT

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ROBAXIN – synthesized in the Robins Research Laboratories, and intensively studied for five years – introduces to the physician an entirely new agent for effective and well-tolerated skeletal muscle relaxation. ROBAXIN is an entirely new chemical formulation, with outstanding clinical properties:

- **Highly potent and long acting.**[5,8]
- **Relatively free of adverse side effects.**[1,2,3,4,6,7]
- **Does not reduce normal muscle strength or reflex activity in ordinary dosage.**[7]
- **Beneficial in 94.4% of cases with acute back pain due to muscle spasm.**[1,3,4,6,7]



CLINICAL RE
DISEASE ENTITY
Acute back pain du
(a) Muscle spasm se to sprain
(b) Muscle spasm du trauma
(c) Muscle spasm du nerve irritation
(d) Muscle spasm se to discogenic dis and postoperati orthopedic proce
Miscellaneous (bursi torticollis, etc.)
TOT



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(Methocarbamol Robins, U.S. Pat. No. 2770649)

Highly specific action

ROBAXIN is highly specific in its action on the internuncial neurons of the spinal cord – with inherently sustained repression of multisynaptic reflexes, but with no demonstrable effect on monosynaptic reflexes. It thus is useful in the control of skeletal muscle spasm, tremor and other manifestations of hyperactivity, as well as the pain incident to spasm, without impairing strength or normal neuromuscular function.

Beneficial in 94.4% of cases tested

When tested in 72 patients with acute back pain involving muscle spasm, ROBAXIN induced marked relief in 59, moderate relief in 6, and slight relief in 3 – or an over-all beneficial effect in 94.4%.[1,3,4,6,7] No side effects occurred in 64 of the patients, and only slight side effects in 8. In studies of 129 patients, moderate or negligible side effects occurred in only 6.2%.[1,2,3,4,6,7]

H ROBAXIN IN ACUTE BACK PAIN[1,3,4,6,7]

F	DURATION OF TREATMENT	DOSE PER DAY (divided)	RESPONSE marked	mod.	slight	neg.	SIDE EFFECTS
	2-42 days	3-6 Gm.	17	1	0	0	None, 16 Dizziness, 1 Slight nausea, 1
	1-42 days	2-6 Gm.	8	1	3	1	None, 12 Nervousness, 1
	4-240 days	2.25-6 Gm.	4	1	0	0	None, 5
	2-28 days	1.5-9 Gm.	24	3	0	3	None, 25 Dizziness, 1 Lightheadedness, 2 Nausea, 2 *
	3-60 days	4-8 Gm.	6	0	0	0	None, 6
			59	6	3	4	*Relieved on reduction of dose

References: 1. Carpenter, E. B.: Publication pending. 2. Carter, C. H.: Personal communication. 3. Forsyth, H. F.: Publication pending. 4. Freund, J.: Personal communication. 5. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: American Pharm. Assn. 46:374, 1957. 6. Nachman, H. M.: Personal communication. 7. O'Doherty, D.: Publication pending. 8. Truitt, E. B., Jr., and

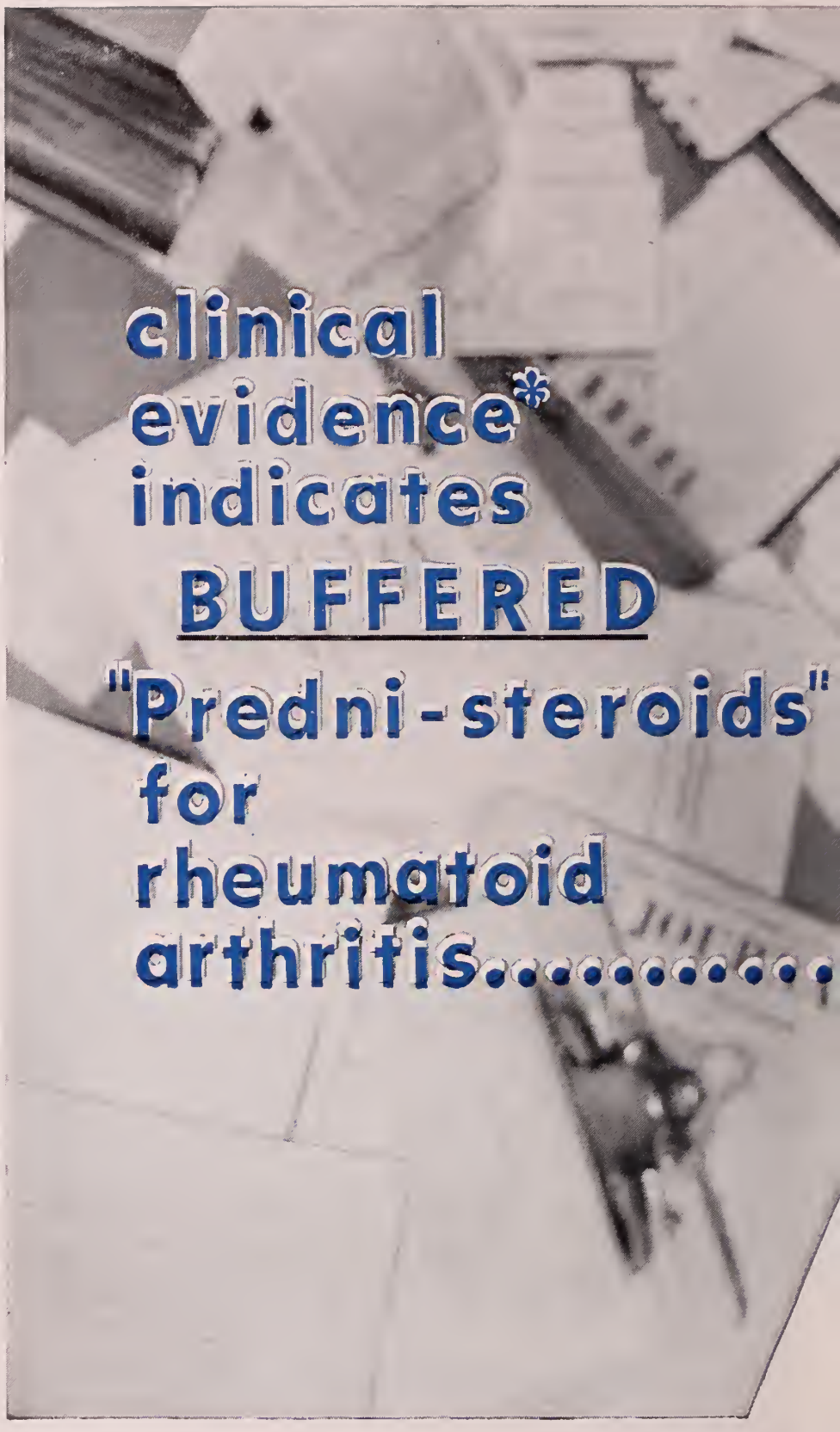
Indications – Acute back pain associated with: (a) muscle spasm secondary to sprain; (b) muscle spasm due to trauma; (c) muscle spasm due to nerve irritation; (d) muscle spasm secondary to discogenic disease and postoperative orthopedic procedures; and miscellaneous conditions, such as bursitis, fibrositis, torticollis, etc.

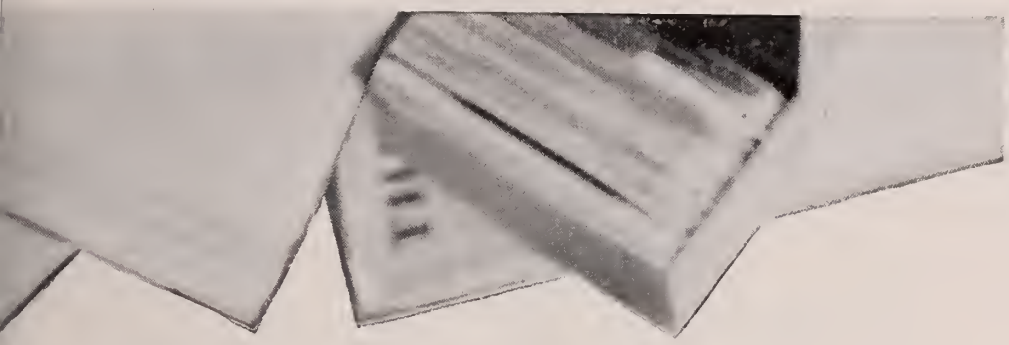
Dosage – Adults: Two tablets 4 times daily to 3 tablets every 4 hours. Total daily dosage: 4 to 9 Gm. in divided doses.

Precautions – There are no specific contraindications to Robaxin and untoward reactions are not to be anticipated. Minor side effects such as lightheadedness, dizziness, nausea may occur rarely in patients with unusual sensitivity to drugs, but disappear on reduction of dosage. When therapy is prolonged routine white blood cell counts should be made since some decrease was noted in 3 patients out of a group of 72 who had received the drug for periods of 30 days or longer.

Supply – Robaxin Tablets, 0.5 Gm., in bottles of 50.

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clinical
evidence*
indicates
BUFFERED
"Predni-steroids"
for
rheumatoid
arthritis.....



Gastric distress accompanying "predni-steroid" therapy is a definite clinical problem—well documented in a growing body of literature.

iew of the beneficial re- observed when antacids d diets were used concom- ith prednisone and predni- e feel that these measures e employed prophylacti- offset any gastrointestinal ts."—Dordick, J. R. *et al.*: te J. Med. 57:2049 (June 7.

*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine co-administration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:459 (June 11) 1955.

One way to make sure that patients receive full benefits of "predni-steroid" therapy plus positive protection against gastric distress is by prescribing CO-DELTRA or CO-HYDELTRA.

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PREDNISONE BUFFERED

ple compressed tablets

provide all the benefits of "Predni-steroid" therapy— plus positive antacid protection against gastric distress

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2.5 mg. or 5.0 mg. of prednisone or prednisolone, plus 300 mg. of dried aluminum hydroxide gel and 50 mg. magnesium trisilicate, in bottles of 30, 100, 500.

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The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

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(Continued from page 1019)

Dr. Cronkite was active in the Broward County Medical Association and was also a member of the Florida Medical Association and the American Medical Association. He was a member of the Florida Society of Pathologists and served as its president in 1953. Active in numerous other organizations of his specialty, he was a fellow of the American College of Pathology, a member of the Mayo Foundation for Medical Research, a fellow of the American Society of Clinical Pathology and an associate member of the American College of Physicians.

Survivors include the widow, Mrs. Margaret Cronkite, and three children, Margaret Anita, Robert Eugene and Ruth Collins, all of Fort Lauderdale; and his parents, of Los Angeles.

Walter Clayton Page

Dr. Walter Clayton Page of Cocoa died in the local hospital on Oct. 23, 1957, after a long illness. He was 71 years of age.

Dr. Page was born at Wrightsville, Ga., in 1885 and was educated in his native state. He received his medical training at the Atlanta Medical College, now Emory University School of Medicine, in Atlanta, and was awarded the degree of Doctor of Medicine in 1910. He entered the general practice of medicine in Live Oak soon after graduation. In 1917 he moved to Cocoa, where he had continued to practice until ill health forced his retirement.

The dean of the local medical profession, Dr. Page had been active in the civic and social life of the community for four decades. He was a Past Master of the local Masonic Lodge.

Dr. Page was active through the years in the Brevard County Medical Society and in 1926 and 1927 served as its president. e was a life member of the Florida Medical Association, holding honorary status at the time of his death. He had been a member of the Association for 44 years and had served as Councilor in his district.

Surviving are two brothers, E. M. Page, of Miami, and C. D. Page, of Vienna, Ga.; three sisters, Miss Cora Page, Miss Evelyn Page, and Mrs. Esther P. Smith, all of Miami; and one niece, Mrs. W. A. Bailey, of Miami. Mrs. Page, the former Florence Bache of Live Oak, died several years ago.



* J.A.M.A. *166*:158,1958; Welsh, A.L. and Ede, M. "...*prompt remissions of...acute phases*," with TARCORTIN

R&C REED & CARNRICK / Jersey City 6, New Jersey

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AN ANTIBIOTIC TRIAD —FOR THE CONTROL OF ALL COCCAL INFECTIONS

FILMTAB®

Erythrocin®

STEARATE (Erythromycin Stearate, Abbott)

against staph-, strep- and pneumococci



Indications

ERYTHROCIN is indicated in treating infections caused by staphylococci, streptococci (including enterococci), and pneumococci. Indicated also, in treating infections that have become resistant to other antibiotics. May be used for patients who are allergic to penicillin or other antibacterials.

Dosage

Usually administered in a total daily dose of 1 to 2 Gm., depending on severity of infection. Suggested dose is 250 mg. every six hours; for severe infections, usual dose is 500 mg. every six hours.

Supplied

In bottles of 25 and 100 *Filmtabs* (100 and 250 mg.). Also, in tasty, cinnamon-flavored oral suspension, in 75-cc. bottles. Each 5-cc. teaspoonful represents 100 mg. of ERYTHROCIN activity.

®Filmtab—Film-sealed tablets, Abbott; pat. applied for.



REMARKABLE EFFECTIVENESS PLUS A SAFETY RECORD UNMATCHED IN SYSTEMIC ANTIBIOTIC THERAPY TODAY

Actually, after almost six years of extensive use, there has not been a single report of a serious reaction to ERYTHROCIN. And, after all this time, the incidence of resistance to ERYTHROCIN has remained exceptionally low.

You'll find ERYTHROCIN is highly effective against the majority of coccal infections and may also be used to counteract complications from severe viral attacks. It comes in *Filmtabs* and in Oral Suspension. Abbott

Compocillin-V®

for those penicillin-sensitive organisms



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Indications

Against all penicillin-sensitive organisms. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and in rheumatic heart disease.

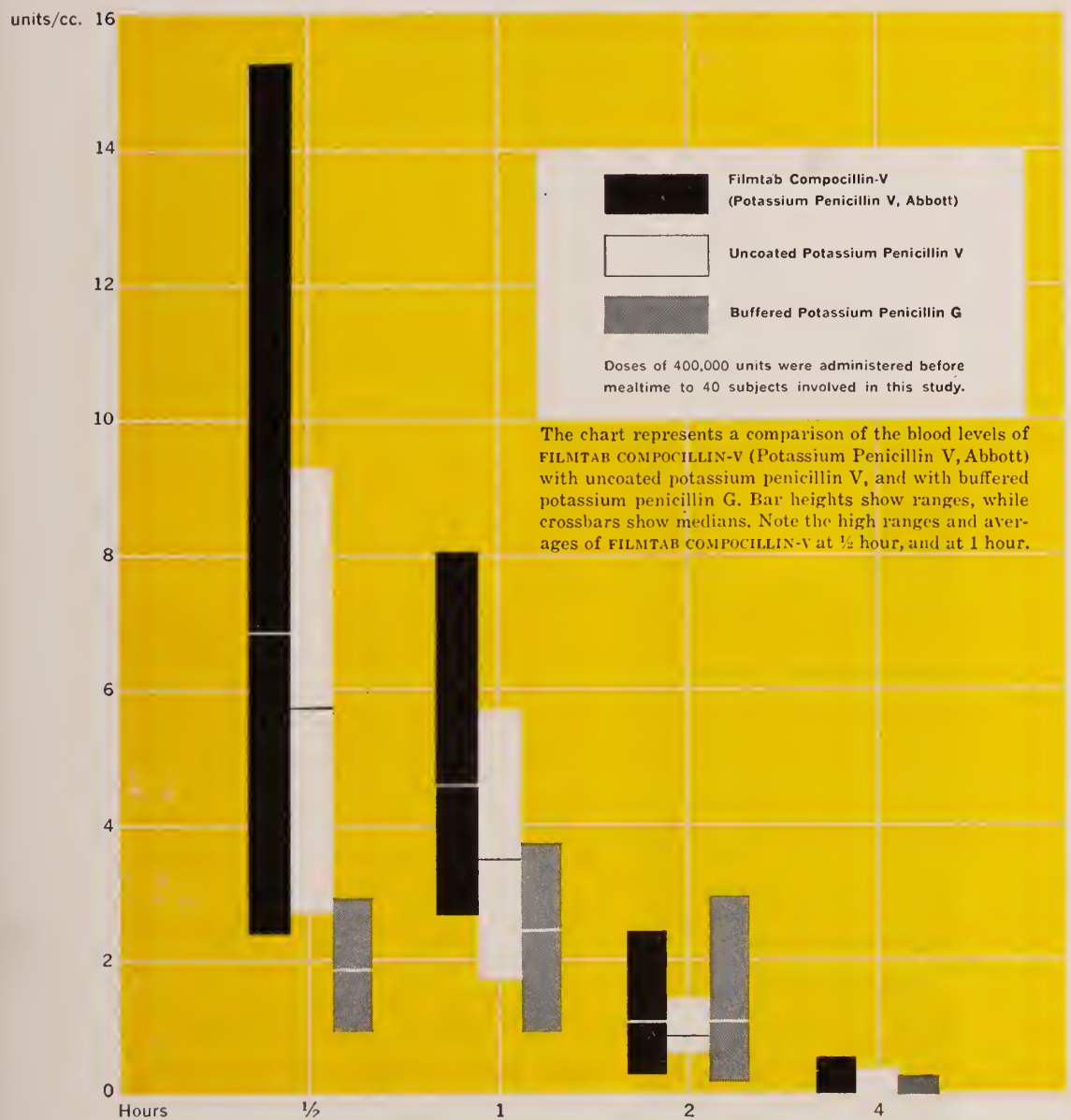
Dosage

Depending on the severity of the infection, 125 to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage is determined by age and weight.

Supplied

Filmtabs COMPOCILLIN-V (Potassium Penicillin V, Abbott) come in 125 mg. (200,000 units), bottles of 50; and in 250 mg. (400,000 units), bottles of 25. Oral Suspension COMPOCILLIN-V (Hydrabamine Penicillin V, Abbott), contains 180 mg. per 5-cc. teaspoonful, in 40-cc. and 80-cc. bottles.

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Now, with *Filmtab* COMPOCILLIN-V, patients get (and within minutes) fast, high penicillin concentrations. Note the blood level chart.

COMPOCILLIN-V is indicated whenever penicillin therapy is desired. It comes in two highly-acceptable forms. *Filmtab* COMPOCILLIN-V offers two therapeutic dosages (125 and 250 mg.). Patients find *Filmtabs* tasteless, odorless and easy-to-swallow. For children, COMPOCILLIN-V comes in a tasty, banana-flavored suspension. It's ready-mixed – stays stable for at least 18 months.

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(Ristocetin, Abbott)

and when coccal infections hospitalize the patient



Indications

SPONTIN is indicated for treating gram-positive bacterial infections. Clinical reports have indicated its effectiveness against a wide range of staphylococcal, streptococcal and pneumococcal infections. It can be considered a drug of choice for the immediate treatment of serious infections caused by organisms resistant to other antibiotics.

Dosage

Recommended dosage depends on the sensitivity of the microorganism and on the severity of the disease under treatment. For pneumococcal and streptococcal infections, a dosage of 25 mg./Kg. per day will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. However, in endocarditis due to relatively resistant strains or where vegetations or abscesses occur, dosages as high as 75 mg./Kg. per day may be used. It is recommended that the daily dosages be divided into two or three equal parts at eight- or twelve-hour intervals.

Supplied

SPONTIN is supplied as a sterile, lyophilized powder, in vials representing 500 mg. of ristocetin activity.

A02070

A LIFESAVING ANTIBIOTIC AFTER OTHER ANTIBIOTICS HAD FAILED



SPONTIN comes to the medical profession with a clinical history of dramatic results — cases where the patients were given little chance of survival.

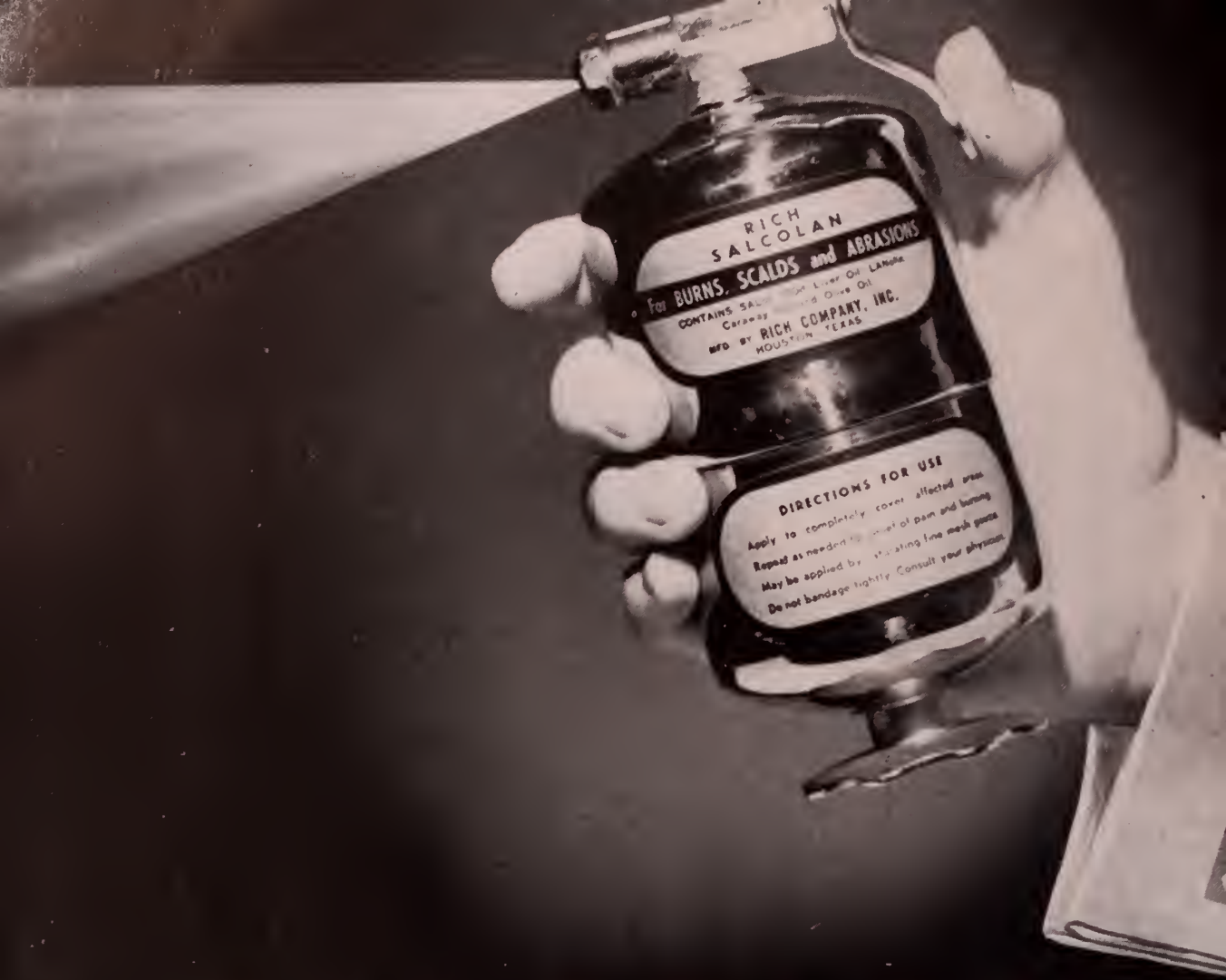
During these careful, clinical investigations, lives were saved after weeks (and sometimes months) of antibiotic failures. These were the cases where the infecting organisms had become resistant to present-day therapy. And, just as important, were the good results found against a wide range of gram-positive coccal infections.

Essentially, SPONTIN is a drug for hospital use, for patients with potentially dangerous infections. In its present form, SPONTIN is administered intravenously using the drip technique. Dosage may be dissolved in 5% dextrose in water or in any isotonic or hypotonic saline solution. Some of the important therapeutic points of SPONTIN include:

1. successful short-term therapy for acute or subacute endocarditis
2. new antimicrobial activity — no natural resistance to SPONTIN was found in tests involving hundreds of coccal strains
3. antimicrobial action against which resistance is rare — and extremely difficult to induce
4. bactericidal action at effective therapeutic dosages.

SPONTIN is truly a lifesaving antibiotic. It could save the life of one of your patients — does your hospital have it stocked?

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SAFE

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• BURNS • SCALDS • ABRASIONS

★ "Initial rapid pain relief, early tissue regrowth, control of secondary infection."

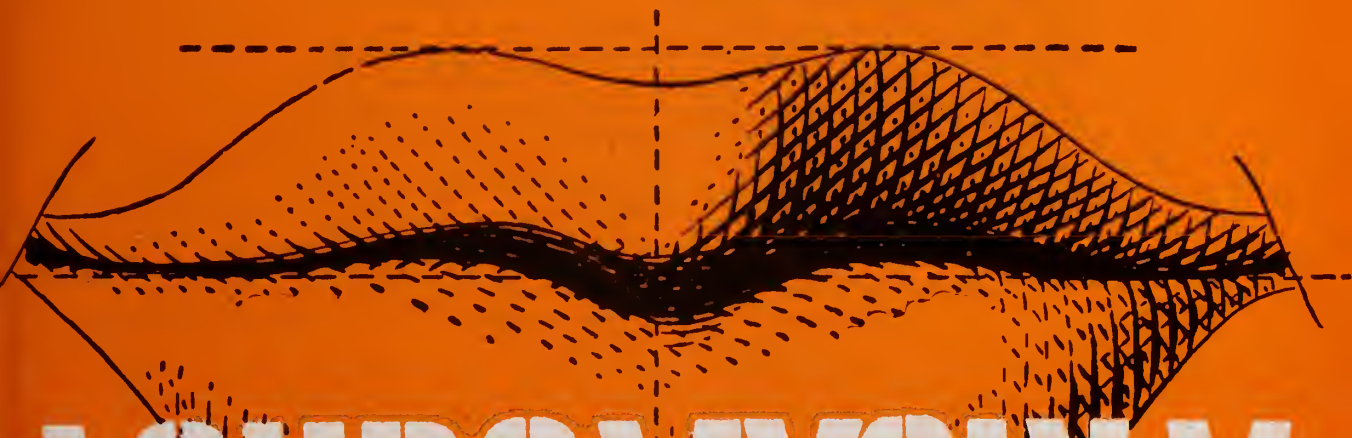
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- early, high peaks of concentration in body tissue and fluid
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- minimal side effects
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Orange Flavor. Each teaspoonful (5 cc.) contains 125 mg. of tetracycline, HCl equivalent, citrate-buffered. Bottles of 2 and 16 fl. oz.

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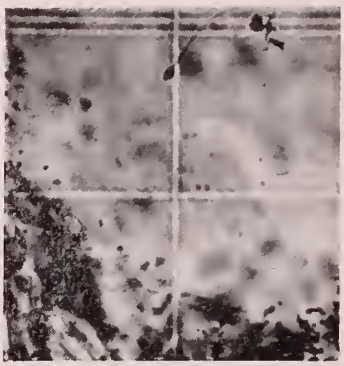
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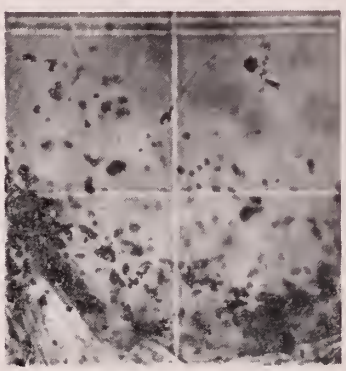
*Goldstein, L. Z.: Obst. & Gynec. *10*:133 (Aug.) 1957.

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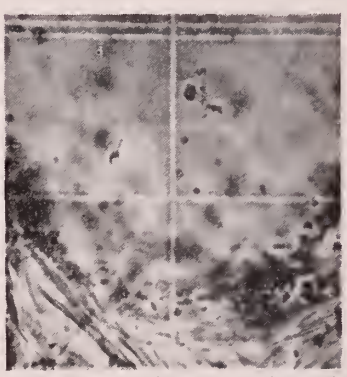
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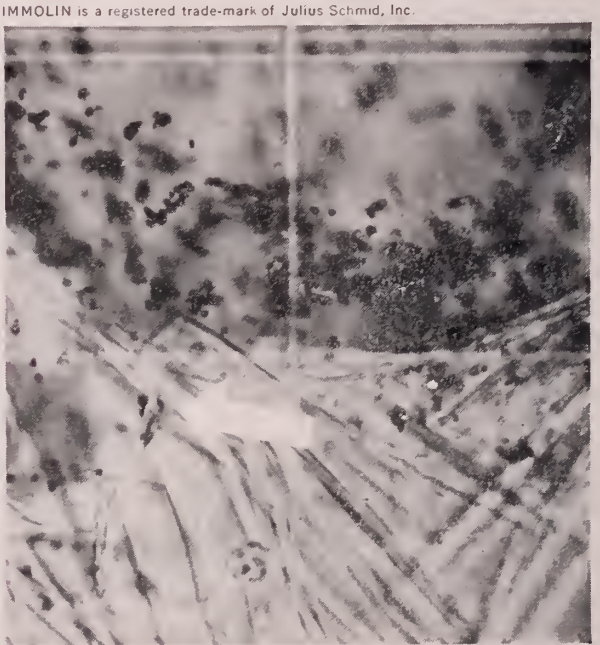
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"It happened at work while he was putting oil in something"



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"But Doctor gave him some nice pills--and the pain went away fast"



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AND THE PAIN WENT AWAY FAST

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ACTS FASTER...
usually within 5-15 minutes

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MORE THOROUGH RELIEF...
permits uninterrupted sleep through the night

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excellent for chronic or bedridden patients

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Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

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While visiting the various County Auxiliaries, the subjects I am most often asked to discuss are the need for an Auxiliary and the advantages of belonging to an Auxiliary. To those of us who have had the privilege of belonging to an active, friendly, working auxiliary, these seem like superfluous questions since to us the answers are self apparent but, with the influx of new doctors and their wives into nearly every county in Florida, these subjects become increasingly important.

Why an Auxiliary? According our Charter, we exist primarily to cultivate friendly relations and to promote mutual understanding among the families of medical doctors; secondly, to carry out projects and programs under the advice of an advisory committee to the end that philanthropic and educational programs may be conducted to assist in the betterment of health and health needs of the people of Florida. All of this sounds like a large order but with 2000, or more, women doing their share, wonders can be accomplished.

More valuable than the actual hours worked in community projects, are the hours of pleasant association spent with other women whose lives and problems are similar to our own and with whom we have mutual interests. Women from all over the United States and foreign countries too, whose lives would never touch ours if it were not for the Auxiliary, become our friends. New friends to be made for the small effort of being friendly ourselves to the stranger in our midst. Soon they are no longer strangers but our dependable friends on whom we can call for help and council in meeting the problems that are faced in any organization.

One auxiliary in this state has adopted a "big sister" program where every new member is sponsored by an older member for the first six meeting after she joins, and in another auxiliary the president calls on every new doctor's wife as soon as her husband applies to the county medical society. These women, who are made

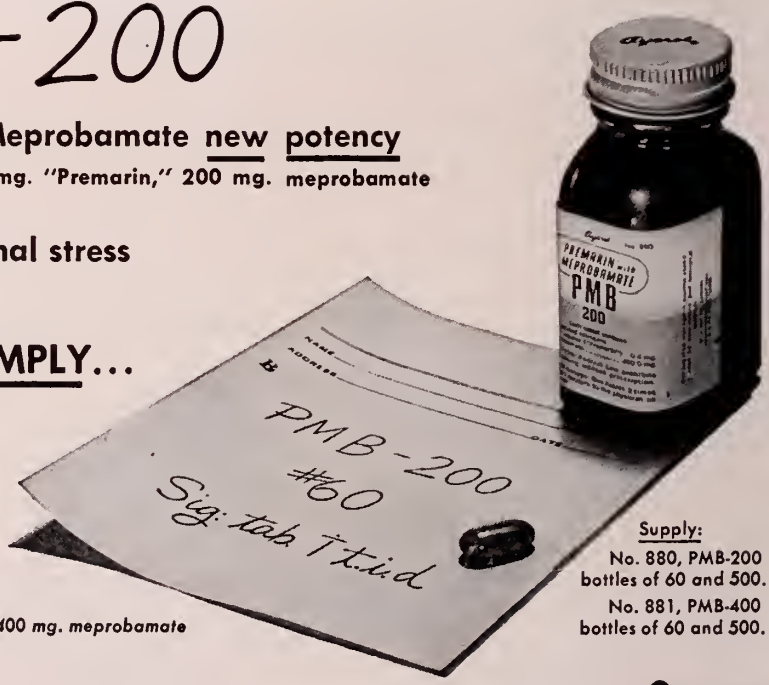
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Each tablet contains 0.4 mg. "Premarin," 200 mg. meprobamate

For undue emotional stress
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Supply:
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A versatile, well-balanced formula offering in one tablet the drugs often prescribed separately for treating upper respiratory infections.

Traditional and nonspecific nasopharyngeal symptoms of malaise and chilly sensations are rapidly relieved, and headache, muscular pain, and pharyngeal and nasal discharges are reduced or eliminated.

Early effective therapy is provided against such bacterial complications as sinusitis, otitis, bronchitis and pneumonitis to which the patient may be highly vulnerable at this time.

Adult dosage for ACHROCIDIN Tablets and new, caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children reduced according to weight and age.

Available on prescription only.

TABLETS *(Sugar-coated)*
Each tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100

SYRUP *(Lemon-lime flavored)*
Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
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Bottle of 4 oz.



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Lederle

so welcome, cannot help but have the kindliest feelings toward the other members of these auxiliaries and her feelings will be reflected by her husband. Doctor's Day is another effort on the part of the Auxiliary to promote better relations among doctors and their families.

As for the programs and projects we carry out, the list goes on and on, and regardless of any woman's taste or talent there will be something she can do that will interest her and further the aims and requests of the local medical society. On the state level, we have eleven project committees starting with the American Medical Education Foundation and going on down through the alphabet to Today's Health, all of which in some way are either educational or philanthropic and conducive to the betterment of health. Our larger auxiliaries can follow the state pattern but in the smaller auxiliaries, we urge that they do only what suits the needs of their community to the limit of their womanpower.

Our members man the medical and health exhibits at state and district fairs. At the annual meeting of the Florida Medical Association, we will aid in the project of giving physical examinations to the members. We are providing prizes for the two teachers whose pupils produce the best health exhibits in the Senior and Junior Division at the State Science Fair. We sponsor the 66 Future Nurse Clubs and expect to have over 300 of these girls at their convention this spring.

I could go on and on but nothing I say can add to the sense of real satisfaction that comes to the women in the Auxiliary when they look back on the worthwhile work done to further their husband's chosen profession and the pleasant and lasting friendships that have come from this work.

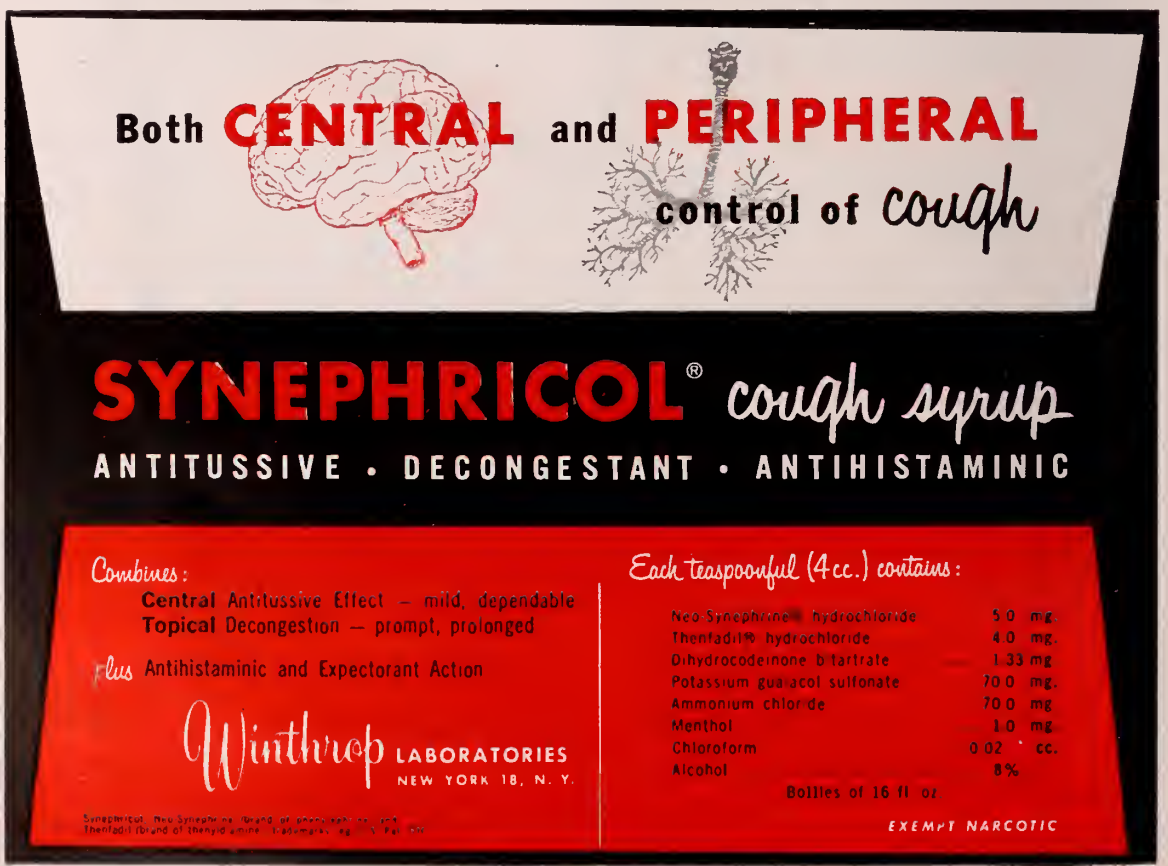
Judith F. Melvin

BOOKS RECEIVED

Practical Gynecology. By Walter J. Reich, M.D., F.A.C.S., F.I.C.S., and Mitchell J. Nechtow, M.D., F.A.C.S., F.I.C.S. Ed. 2. Pp. 648. Illus. 284. Price, $12.50. Philadelphia, J. B. Lippincott Company, 1957.

This is a book designed principally for use by the general practitioner in the office practice of gynecology. It places the diagnosis and treatment of female disorders within the framework of medicine as a whole. Every effort is made to practicalize and simplify, basing discussion solidly on the best in modern practice. At the same time, through its concisely informative presentation, the book manages to provide a complete coverage of the entire field. A common sense evaluation of the emotional implications for the patient of the various conditions considered is a widely praised feature of the text. Throughout the book there is full consideration of the newer concepts and current practices in gynecology as

(Continued on page 1046)





when you encounter

- respiratory infections
- gastrointestinal infections
- genitourinary infections
- miscellaneous infections

for all tetracycline-amenable infections, prescribe superior

SUMYCIN

Squibb Tetracycline Phosphate Complex

In your patients, **SUMYCIN** *produces:*

1. Superior initial tetracycline blood levels—faster and higher than ever before—assuring fast transport of adequate tetracycline to the site of the infection.

2. High degree of freedom from annoying or therapy-interrupting side effects.

Supply:	*Tetracycline phosphate complex equiv. to tetracycline HCl (mg.)*	*Packaging:*
Sumycin Capsules (per Capsule)	250	Bottles of 16 and 100
Sumycin Suspension (per 5 cc.)	125	2 oz. bottles
Sumycin Pediatric Drops (per cc.—20 drops)	100	10 cc. dropper bottles

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MEDICAL
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EXCLUSIVELY

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WE COVER
YOU WITH—
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of, 100,000/300,000
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50,000 for Property
Damage

You Are Protected
With 100% Coverage
On Collision, Fire
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If Your Car
Is Out of Service, You
Are Provided With a
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All Repairs, Tire &
Battery Replacement
Are Purchased In
Your Home Town

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CODEINE PHOSPHATE*

maximum codeine analgesia/optimum antipyretic action

*Subject to Federal Narcotic Regulations



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...from moderate to severe pain complicated by tension, anxiety and restlessness.

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Codeine Phosphate gr. ¼
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Acetophenetidin gr. 2½
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A few suggestions on how to give your patient a diet he can "stick to"—

The Low Calorie Diet

—and a glass of beer, at your discretion, for a morale-booster

A diet that calls for lamb chops when they aren't on the restaurant menu is an invitation to "slip off." But a diet outline that lets your patient fill in the details provides incentive to stick to his diet.

He must remember that a candy bar equals a hamburger in calories only. An alternative must be equivalent in nutrition, too.

Fresh fruits or vegetables such as celery and radishes make good low-calorie nibbles. Spices and herbs, lemon and vinegar add zest with few or no calories.

Have your patient keep a calorie count. Then with a glass of beer* to brighten meals, he is more likely to follow a balanced diet later.

*104 Calories/8 oz. glass (Average of American Beers)

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Beer—America's Beverage of Moderation

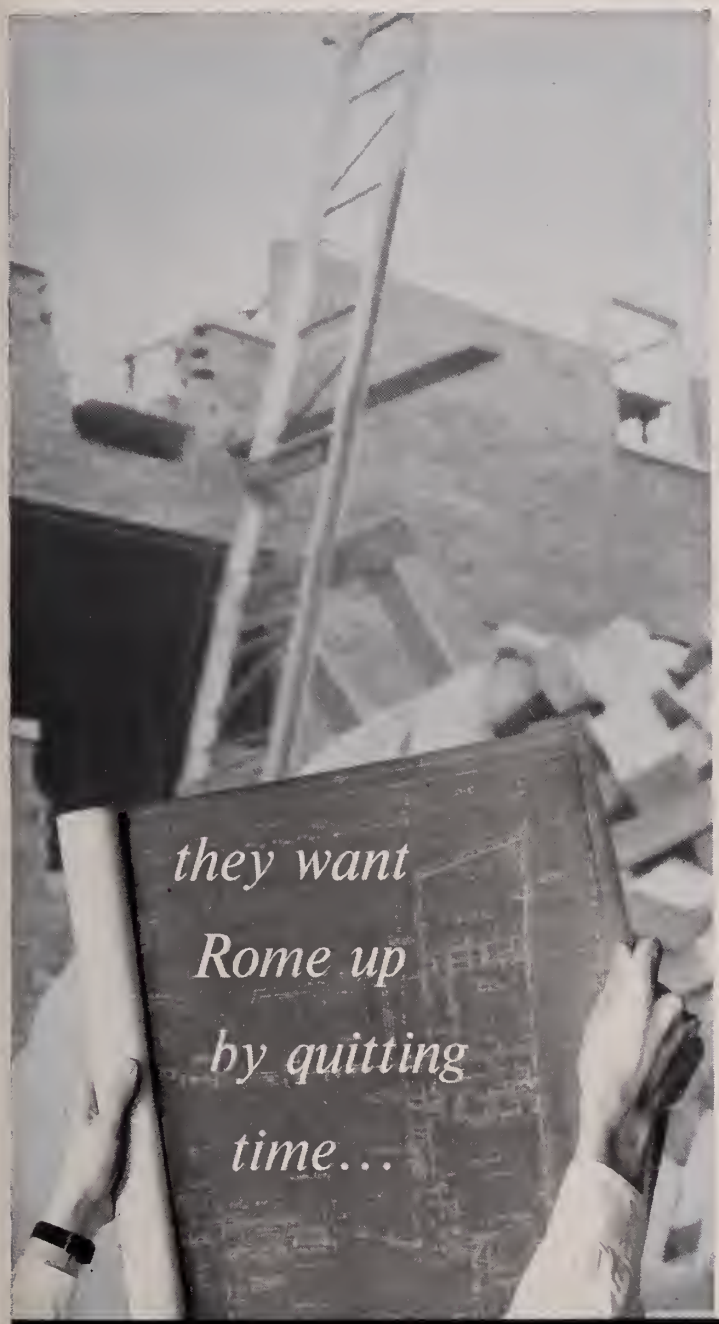
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To cut daytime lethargy

(and keep rauwolfia potency)

in treatment of hypertension:

Mounting clinical evidence confirms the view that HARMONYL produces much less lethargy while reducing blood pressure effectively. In the most recent study[1], HARMONYL was evaluated in comparison with reserpine and other rauwolfia alkaloids. HARMONYL *was the only alkaloid which produced a hypotensive response closely matching that of reserpine, coupled with a greatly reduced rate of lethargy.* Only one HARMONYL patient in 20 showed lethargy, while an average of 11 out of 20 showed lethargy with reserpine, and 10 out of 20 with the alseroxylon fraction. Abbott

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for your hypertensives who must stay on the job

Harmonyl*

(DESERPIDINE, ABBOTT)

while the drug works effectively . . . so does the patient

1. Comparative Effects of Various Rauwolfia Alkaloids in Hypertension; *Diseases of the Chest*, in press.

*TRADEMARK

(Continued from page 1040)

well as authoritative description of basic and time-tested methods and procedures. Nine entirely new chapters have been added to this second edition: Cytology in Gynecology, Acute Gynecologic Abdomen, Fibroids of the Uterus, Tumors of the Ovary, Radiation Therapy in Gynecology, Pediatric Gynecology, Geriatrics, The Role of the Male in Gynecology, and Pitfalls in Gynecologic Diagnosis. A section has been added on the diagnosis of early pregnancy, and considerable new material has been incorporated in the chapter on the examination of the breast. Sixty-eight subjects are in color, and many new and original photographs have been added. The book lives up to its title.

Chronic Illness in the United States. Volume I. Prevention of Chronic Illness. Commission on Chronic Illness. Pp. 338. Price, $6.00. Published for The Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1957.

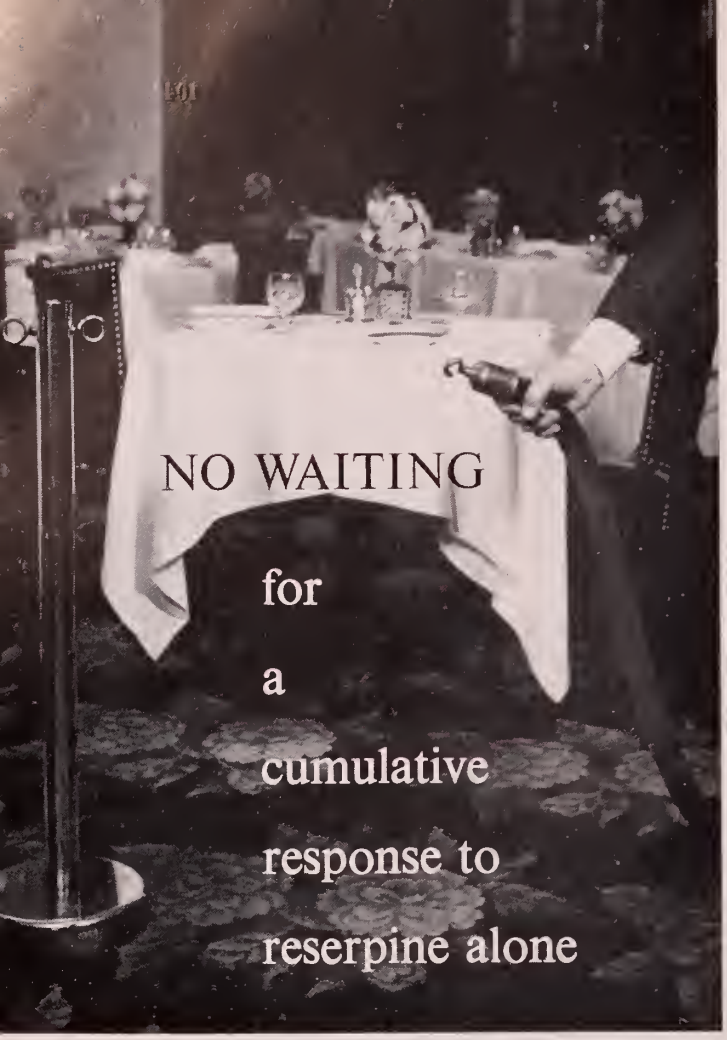
Prevention is the subject of this, the first volume of the four volume report, Chronic Illness in the United States. How can the concept of prevention be instilled in students of medicine, nursing and social work, in health education, and in related disciplines? What organizational patterns will be most effective for the administration of preventive programs? How can the public be moved to adopt and support preventive measures? It is these questions that this book is designed to explore.

Part I of this volume presents 21 conclusions and recommendations concerning prevention which were adopted by the Commission on Chronic Illness in February 1956. Part II is a series of summaries on the preventive aspects of most of the major chronic diseases and impairments and on several of the most important factors contributing to them. These summary statements, prepared originally for the National Conference on the Preventive Aspects of Chronic Disease, were revised in 1956 by the persons or organizations originally responsible for their preparation. Many of the summaries are followed by bibliographies.

Physicians and medical social workers; health and welfare workers; and the research, teaching, practicing, and nursing staffs of hospitals across the country will all find that this book presents a valuable compendium of information and of leads to further research. This is another important Commonwealth Fund book.

Your Wonderful Body. By Peter Pineo Chase, M.D. Pp. 391. Illus. 70. Price, $5.95. Englewood Cliffs, N. J., Prentice-Hall, Inc., 1957.

Dr. Chase, distinguished physician, author and for many years editor of the Rhode Island Medical Journal, is at his best in this fascinating, factual and yet easy-to-read account of the miraculous complexity of the human body and how to keep it healthy. His cheerful, pithy explanations help one understand how the body functions in part and as a whole, the interconnection and interdependence of all its elements, the change it undergoes and its awe-inspiring power to renew itself. There is sound medical advice on a variety of such vital subjects as: the origin and development of the body; childbirth; child-rearing; the skin, bones, and muscles; circulation and blood; digestion, respiration and excretion; the nervous system and sense organs; vitamins and hormones; reproduction and heredity; rest and pain, inflammation, immunity, repair; emotions; drugs; allergies; and a final section on Dr. Chase's inimitable medical philosophy. Here, in this introduction for laymen to the fascinating complexities of the human body, the reader finds an admirable expression of the author's personality and experience, his wit and humor, and his cheerful, optimistic approach to good health and a long and happy life.



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NEW *fast-acting*

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Harmonyl-N*

(Harmonyl* and Nembutal®)

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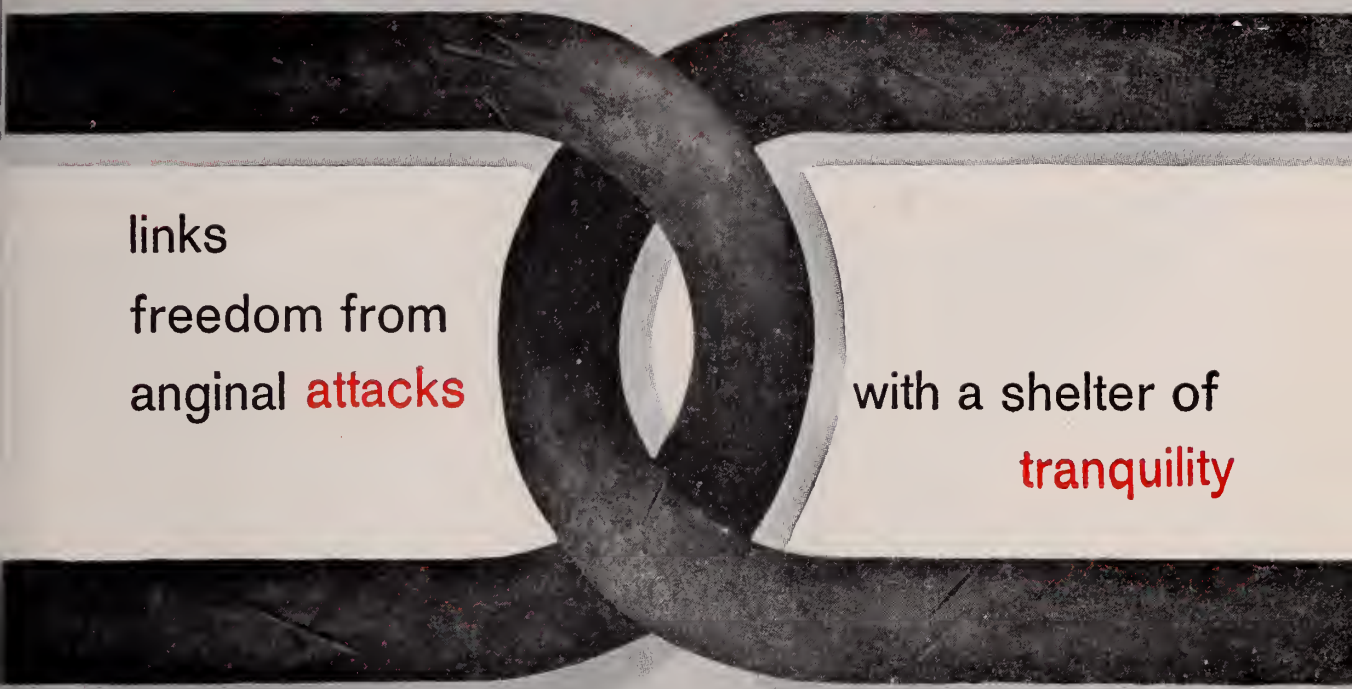
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links
freedom from
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with a shelter of
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In pain. Anxious. Fearful. On the road to cardiac invalidism. These are the pathways of angina patients. For fear and pain are inexorably linked in the angina syndrome.

For angina patients—perhaps the next one who enters your office—won't you consider new CARTRAX? This doubly effective therapy combines PETN (pentaerythritol tetranitrate) for lasting vasodilation and ATARAX for peace of mind. Thus CARTRAX relieves not only the anginal pain but reduces the concomitant anxiety.

Dosage and supplied: begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated, this may be increased for more optimal effect by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100. CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

"Cardiac patients who show significant manifestations of anxiety should receive ataractic treatment as part of the therapeutic approach to the cardiac problem."[1]

1. Waldman, S., and Pelner, L.: Am. Pract. & Digest Treat. *8*:1075 (July) 1957.

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"finger-itis"

there's pain and inflammation here... it could be mild or severe, acute or chronic, primary or secondary fibrositis—or even early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

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. . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function.

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. . . much less likelihood of treatment-interrupt side effects[1-6]

. . . simple, flexible dosage schedule



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it calls for

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corticoid-salicylate compound

tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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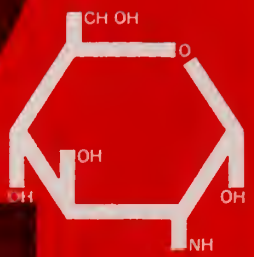
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1 ***Highest, fastest tetracycline blood levels,*** with glucosamine enhancement. A screening program involving 84 possible adjuvants, multiple four way crossover tests, 30,000 blood level determinations and more than 100,000 assays proved glucosamine to be the enhancing agent of choice.

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The most widely prescribed broad-spectrum antibiotic now potentiated with glucosamine, the enhancing agent of choice

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Capsules, 250 mg., 125 mg.
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With type as well as amount of fat in the human diet now assuming such importance, the new role of corn oil as a source of unsaturated fatty acids has prompted these questions:

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answer: By balancing the types of fat in the daily diet. Many doctors now agree that from one third to one half of the total fat intake should be in the form of a vegetable oil such as corn oil (MAZOLA).

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Whether the eventual solution of the problem of atherogenesis will come out of the field of dietetics, biophysics, or pharmacology, one fact remains undeniable:

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Meat is outstanding among protein foods. It supplies all the essential amino acids, and closely approaches the quantitative proportions needed for biosynthesis of human tissue.

In addition, it is an excellent source of B vitamins, including B_6 and B_{12}, as well as iron, phosphorus, potassium, and magnesium.

When curtailment of fat intake is deemed indicated, meat need not always be denied the patient. Visible fat obviously should not be eaten. But the contained percentage of invisible (interstitial) fat is well within the limits of reasonable fat allowance.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

when anxiety and tension "erupts" in the G. I. tract...

IN DUODENAL ULCER



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Meprobamate with PATHILON® Lederle

Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of duodenal ulcer — without fear of barbiturate loginess, hangover or habituation . . . *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

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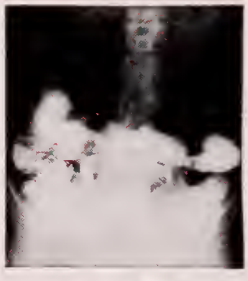
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when anxiety and tension "erupts" in the G. I. tract...

IN ILEITIS



PATHIBAMATE*

Meprobamate with PATHILON® Lederle

Combines Meprobamate (*400 mg.*) the most widely prescribed tranquilizer . . . helps control the "emotional overlay" of ileitis — without fear of barbiturate loginess, hangover or habituation . . . *with* PATHILON (*25 mg.*) the anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of many G.I. disorders.

Dosage: 1 tablet t.i.d. at mealtime. 2 tablets at bedtime. *Supplied:* Bottles of 100, 1,000.

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LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

How Old is Too Old for Tranquilizers ?

The psychological needs of the elderly confront physicians with one of their most perplexing problems. Perhaps no other patient group suffers so much from emotional distress. Yet, precisely because of their age, geriatric patients often seem beyond the reach of tranquilizing treatment.

When tranquilization seems risky . . .

They are too much beset by complicating chronic ailments, too susceptible to serious side effects. Ataraxia is clearly indicated, yet the doctor cannot risk side reactions on liver, blood or nervous system.

Is there an answer to this dilemma?

We feel there is. In four recent papers investigators have reported good results with ATARAX in patients up to 90 years of age.* In one study, **improvement was "pronounced" in 76%, "good" in an additional 18.5%.*** ATARAX has been successfully used in such cases as senile anxiety, agitation, hyperemotivity and persecution complex.* On ATARAX, patients became ". . . quieter and more manageable. They slept better and demonstrated improved relations with other patients and hospital personnel. Even their personal hygiene improved, and they required less supervisory management."*

. . . ATARAX is safe

Yet even in the aged, ATARAX has given "no evidence of toxicity. . . . Complete liver function tests and blood studies were made on all patients after two months of therapy. . . . There were no significant abnormalities."* With still other elderly patients "tolerance to the drug was excellent, even in cases where the patients were given relatively high doses."* Similarly, no parkinsonian effects have been observed on ATARAX therapy.

Nor does ATARAX make your patients want to sleep all day. Instead, they can better take care of themselves, because ATARAX leaves them both calm and alert. In sum, ATARAX ". . . does not impair psychic function and has a minimum of side effects. . . . It appears that ATARAX is a safe drug. . . ."*

These, undoubtedly, are the results you want when emotional problems beset your geriatric patients. For the next four weeks, won't you prescribe tiny ATARAX tablets or pleasant-tasting ATARAX syrup — both so readily acceptable to the elderly.

*Documentation on request

ATARAX®
(BRAND OF HYDROXYZINE)

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Medical Director

ATARAX
n any
nyperemotive
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or childhood behavior disorders
10 mg. tablets—3-6 years, one tablet t.i.d.; over 6 years, two tablets t.i.d. Syrup—3-6 years, one tsp. t.i.d.; over 6 years, two tsp. t.i.d.

or adult tension and anxiety
25 mg. tablets—one tablet q.i.d. Syrup—one tbsp. q.i.d.

or severe emotional disturbances
100 mg. tablets—one tablet t.i.d.

or adult psychiatric and emotional emergencies
Parenteral Solution—25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

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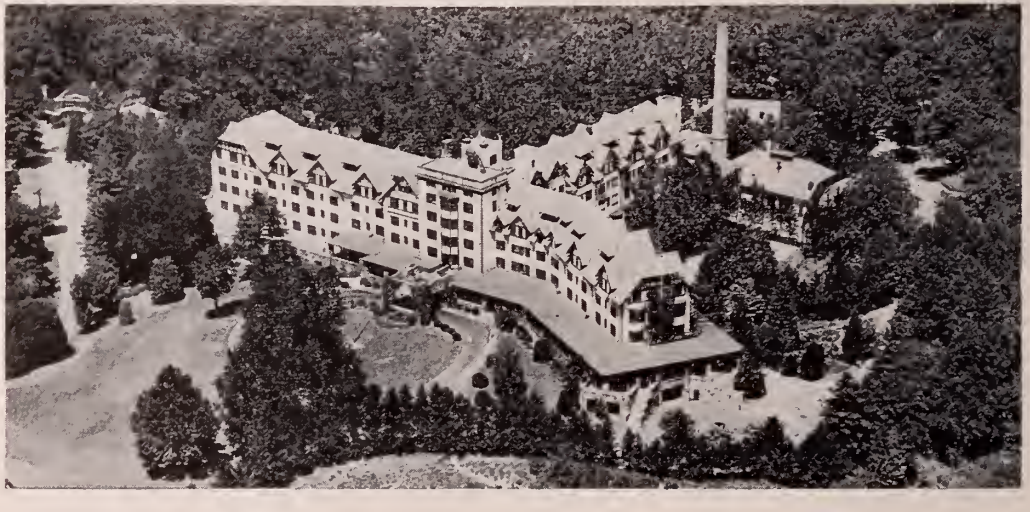
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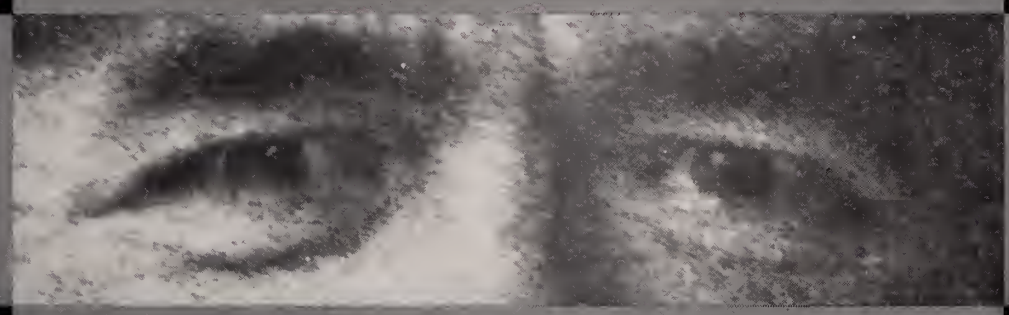
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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	ACTIVE MEMBERS
Alachua	G. Leonard Emmel, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	64
* *Bradford, Gilchrist, Union*				
Bay	Sidney E. Daffin, Panama City	Henry C. Smallwood, Panama City	1st Tues.	29
Brevard	Jack T. Bechtel, Eau Gallie	Cyrus E. Warden, Melbourne	2nd Tues.	53
Broward	Russell R. Hippensteel, Hollywood	Garland M. Johnson, Ft. Lauderdale	4th Tues.	182
Collier	Reidar Trygstad, Naples	Ethel H. Trygstad, Naples	3rd Wed.	9
Columbia	Robert M. Sasso, Lake City	Louis G. Landrum, Lake City	1st Mon.	11
* *Baker*				
Dade	Nelson Zivitz, Miami	Geo. W. Robertson III, Miami	1st Tues.	808
DeSoto-Hardee-Highlands-Glades	Charles H. Kirkpatrick, Arcadia	Gordon H. McSwain, Arcadia	1st Tues.	28
Duval	Ashbel C. Williams, Jacksonville	William J. Knauer Jr., Jacksonville	1st Tues.	334
* *Clay*				
Escambia	Joseph W. Douglas, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	113
Franklin-Gulf	William F. Wager, Port St. Joe	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	Wesley W. Wilson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	225
Indian River	Enoch J. Vann Jr., Vero Beach	Charles F. Rattray, Vero Beach	2nd Tues.	9
Jackson-Calhoun	Sarah M. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	15
Lake	Geo. E. Engelhard, Leesburg	Frederick C. Andrews, Mt. Dora	1st Wed.	26
* *Sumter*				
Lee-Charlotte-Hendry	Gustave F. Bieber, Ft. Myers	William M. Taylor, Ft. Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	T. Bert Fletcher Jr., Tallahassee	Nelson H. Kraeft, Tallahassee	3rd Mon.	72
Madison	Wilmer J. Coggins, Madison	Julian M. DuRant, Madison	Quarterly	8
Manatee	Eugene E. Biel, Bradenton	Irving E. Hall Jr., Bradenton	2nd Tues.	31
Marion	Harry M. Edwards, Ocala	Charles H. Marks, Ocala	3rd Tues.	33
* *Levy*				
Monroe	William R. Ploss, Key West	Walter R. McCook, Key West	1st Thurs.	13
Nassau	Benjamin F. Dickens, Fernandina Bch.	David D. Bennett, Callahan	1st Thurs.	8
Orange	Robert E. Zellner, Orlando	Robert W. Curry, Orlando	3rd Wed.	219
* *Osceola*				
Palm Beach	W. Lawson Shackelford, W. Palm Bch.	Robert Y. Wheelihan, Riviera Bch.	4th Mon.	162
Pasco-Hernando-Citrus	S. Carnes Harvard, Brooksville	W. Wardlaw Jones, Dade City	2nd Thurs.	20
Pinellas	Whitman H. McConnell, St. Pete	Whitman C. McConnell, St. Pete	1st Mon.	253
Polk	Marion W. Hester, Lakeland	Charles Larsen Jr., Lakeland	2nd Wed.	111
Putnam	Bennie J. Massey, Palatka	Fairfax E. Montague, Palatka	2nd Tues.	10
St. Johns	Thomas L. Glennan, Green Cove Spgs.	Walter W. Weigel, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Howard C. McDermid, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	29
Sarasota	Karl R. Rolls, Sarasota	James E. Kicklighter, Sarasota	2nd Tues.	67
Seminole	Daniel H. Mathers, Sanford	Terry Bird, Sanford	2nd Tues.	15
Suwannee-Hamilton-Lafayette	Irby H. Black, Live Oak	Hugo F. Sotolongo, Live Oak	1st Sat.	11
Taylor	John A. Dyal Jr., Perry	Charles R. Wiley, Perry	Last Fri.	6
* *Dixie*				
Volusia	Achille A. Monaco, Daytona Bch.	John J Cheleden, Daytona Bch.	2nd Tues.	86
* *Flagler*				
Walton-Okaloosa-Santa Rosa	Howard A. Parker, Valparaiso	Eric F. Geiger, Milton	3rd Tues.	27
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay		3
			Total	3,154

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Source—Hyman, M.: Some Aspects of Psychiatry in General Practice, GP *16*:83 (Oct.) 1957.

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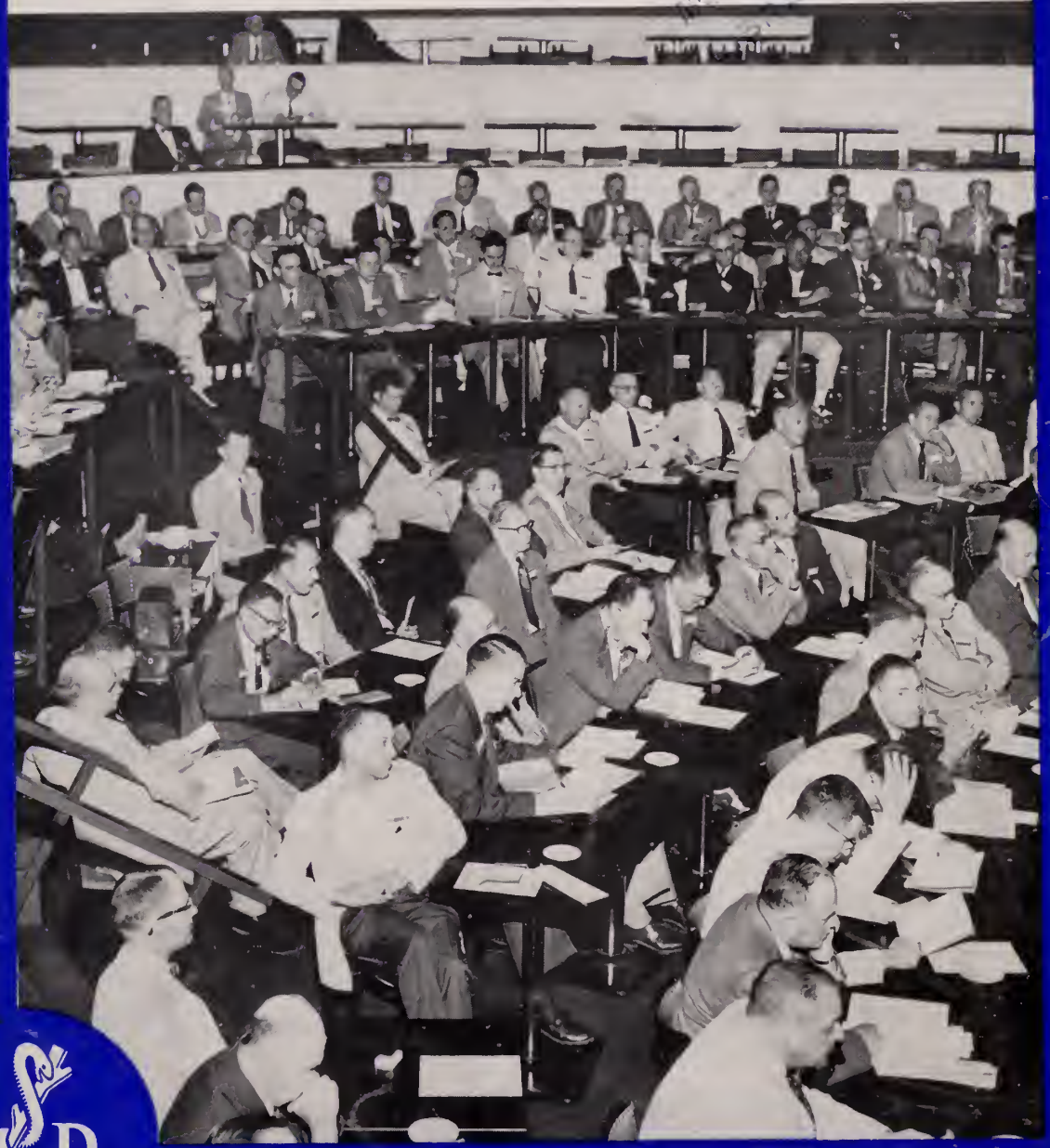
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References: (1) Greenblatt, R. B., & Clark, S. L.: M. Clin. North America, Philadelphia, W. B. Saunders Company (Mar.) 1957, p. 587. (2) Greenblatt, R. B.: *J. Clin. Endocrinol.* *16*:869, 1956. (3) Hertz, R.; Waite, J. H., & Thomas, L. B.: *Proc. Soc. Exper. Biol. & Med.* *91*:418, 1956.

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924

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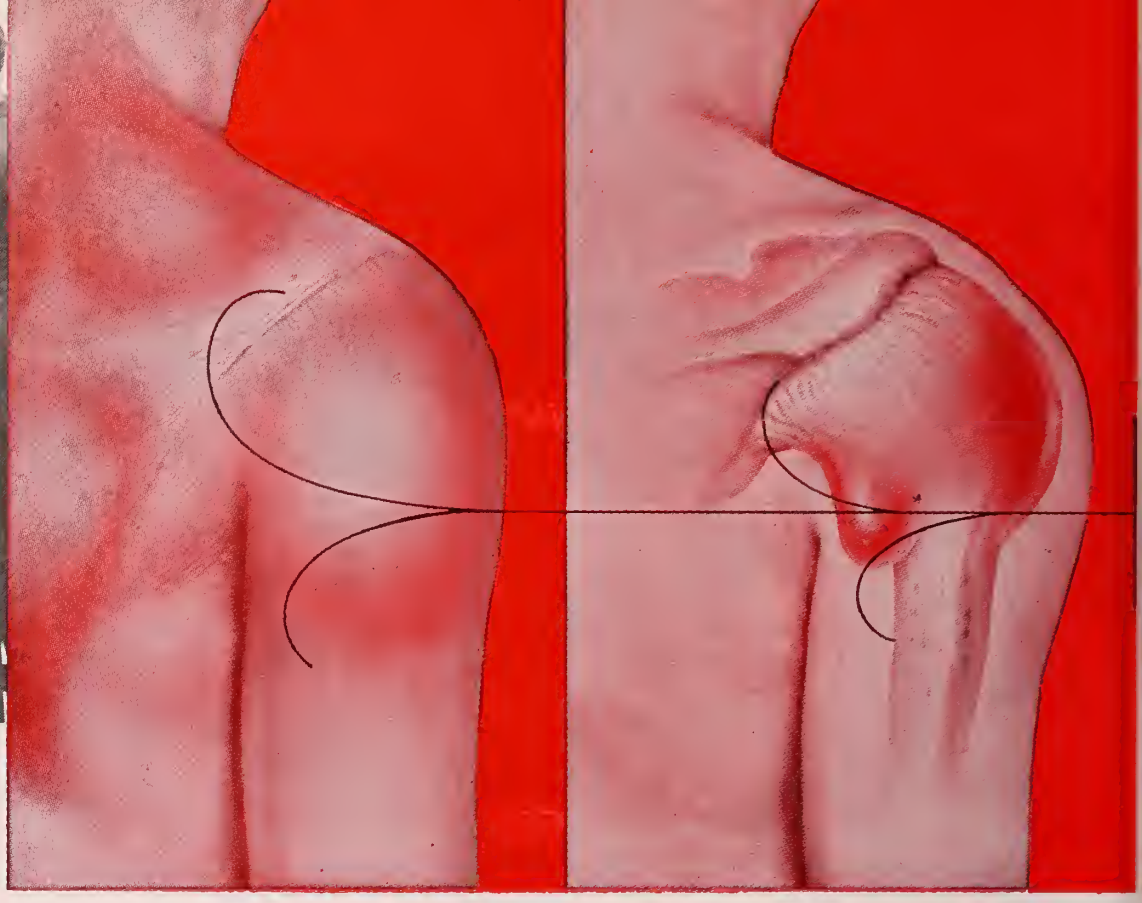
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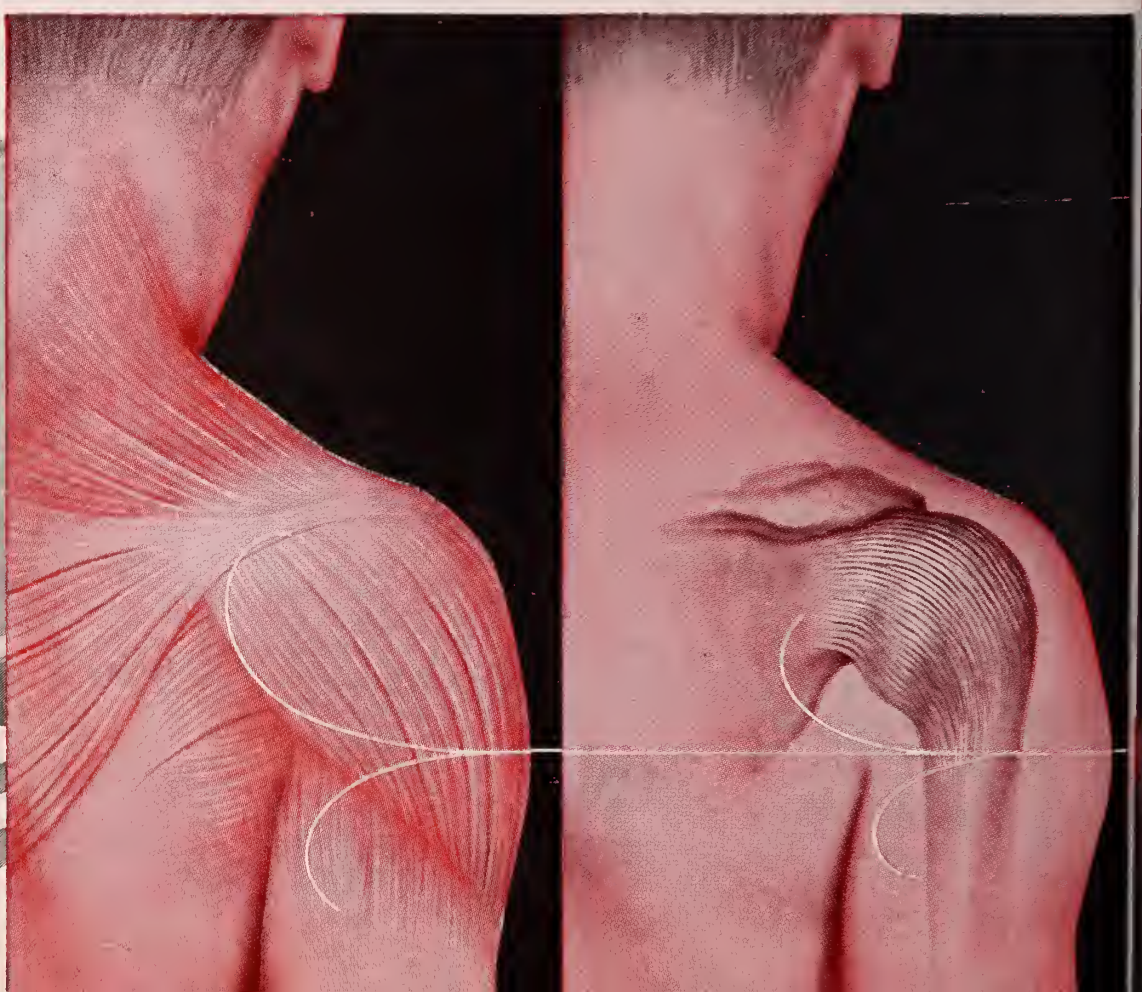
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1. Comroe's Arthritis: Hollander, J. L., p. 149 (Fifth Edition, Lea & Febiger, Philadelphia, Pa. 1953).
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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

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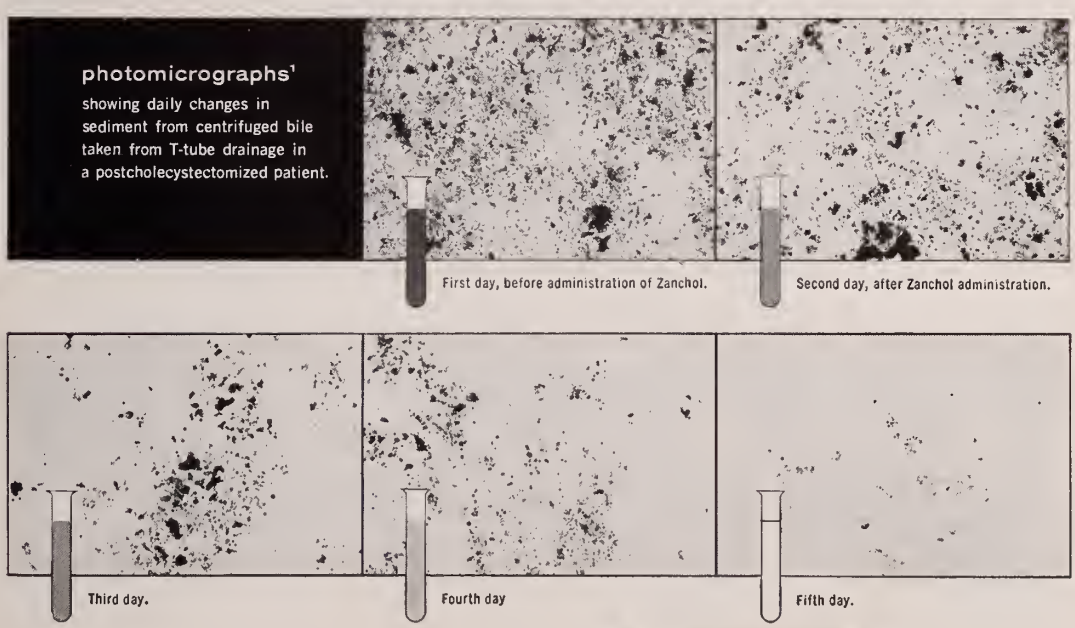
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1. McGowan, J. M.: Clinical Significance of Changes in Common Duct Bile Resulting from a New Synthetic Choleretic, Surg., Gynec. & Obst. *103*:163 (Aug.) 1956.

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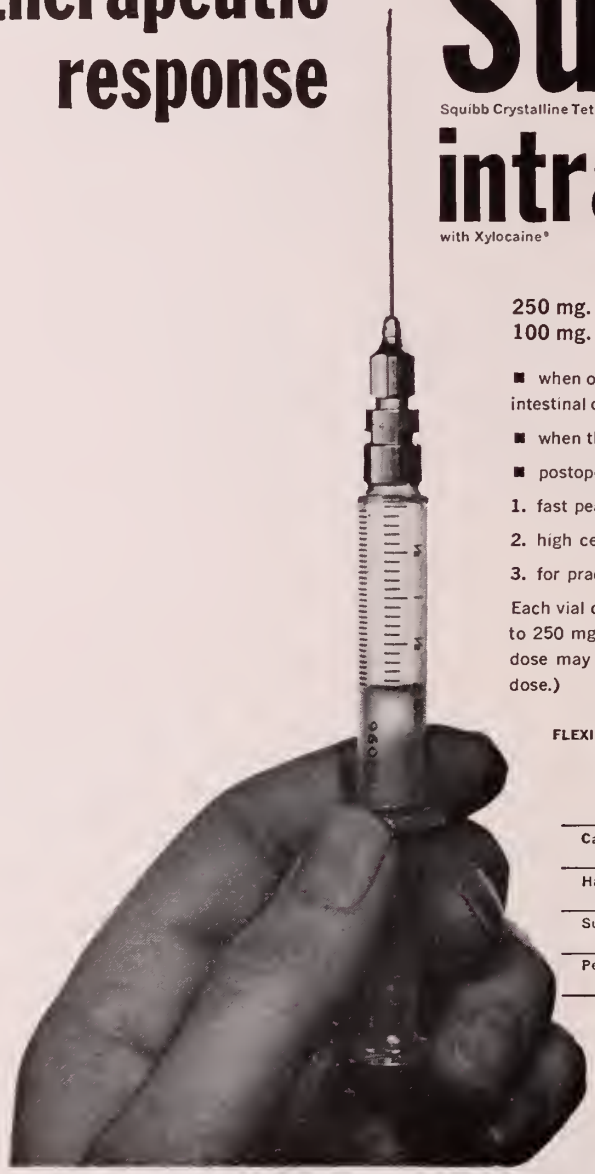
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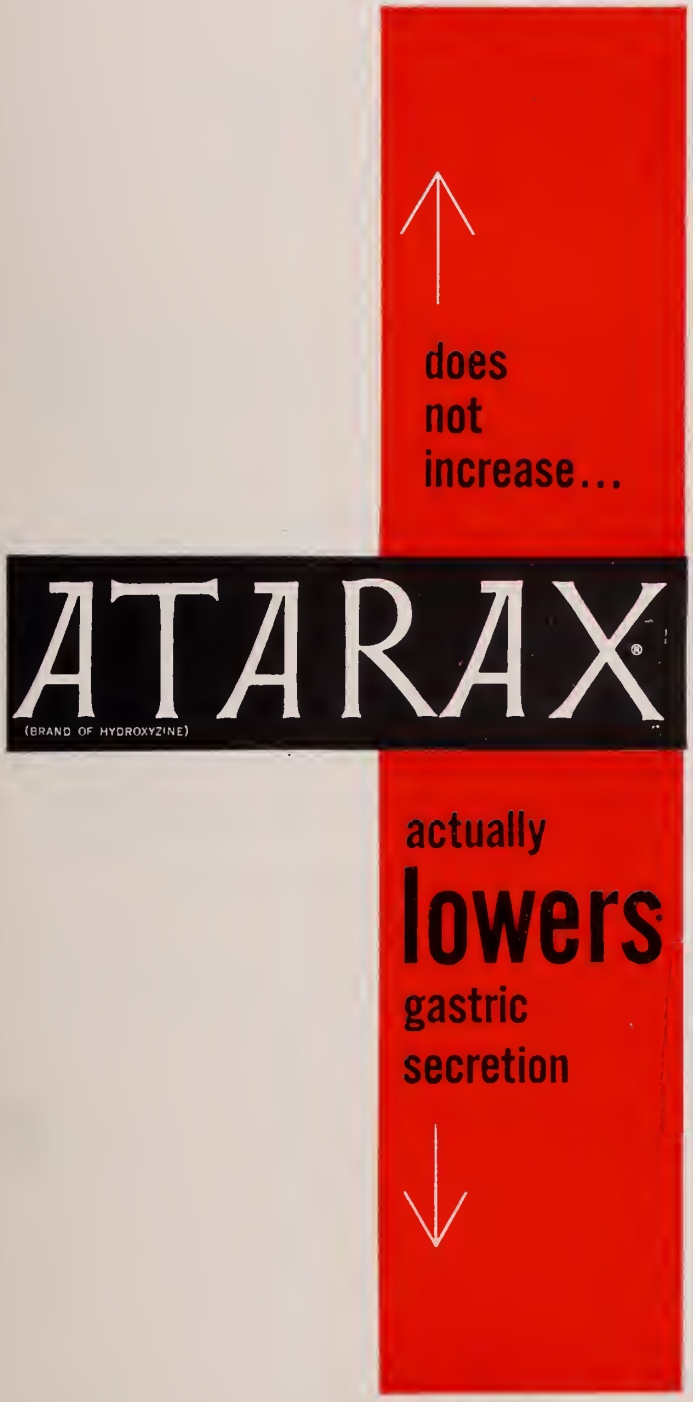
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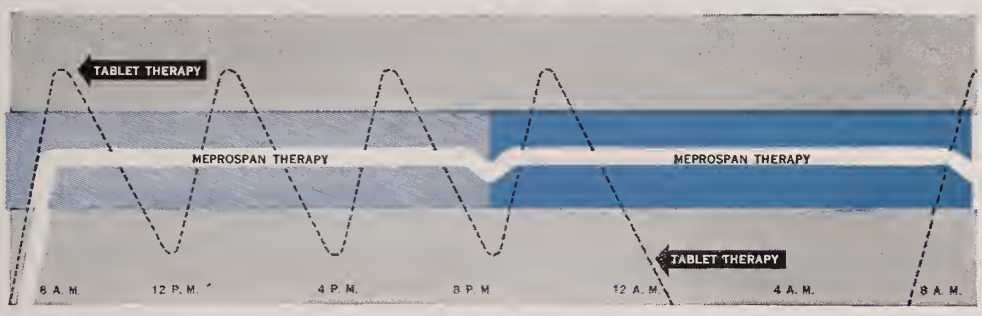
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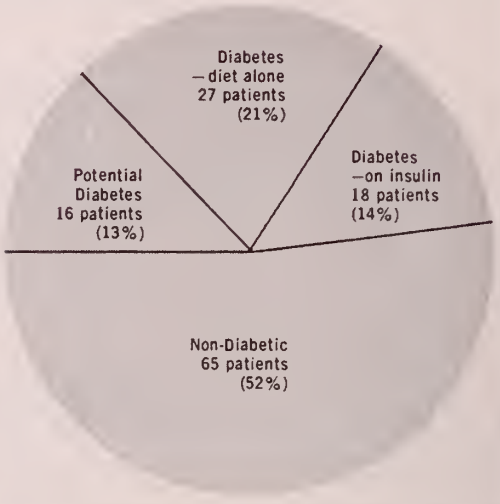
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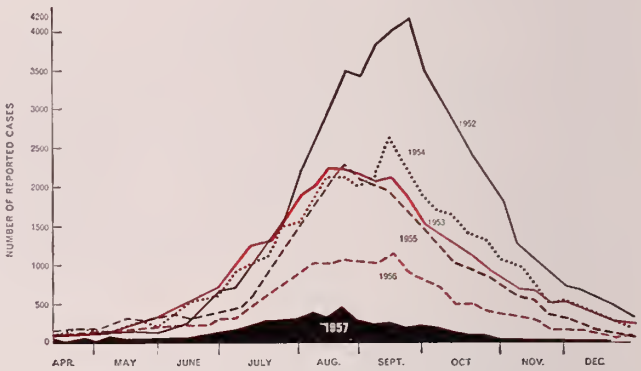
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1. *J. A. M. A.*, 165:21 *(November 23)*, *1957.*
2. *Department of Health, Education, and Welfare: News Release, October 10, 1957.*



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The Journal of The Florida Medical Association
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Volume XLIV | Jacksonville, Florida, April, 1958 | No. 10

New Technics in the Study of Carcinoma Of the Uterine Cervix

Sam W. Denham, M.D.
AND
Alvan G. Foraker, M.D.
JACKSONVILLE

The growth patterns of the normal cervix have become important in understanding the abnormal growth behavior of malignant tissue. Histochemical reactions are now known to be reliable indicators of these growth processes. The natural history and course of events in untreated cervical cancer have been known for years. It soon became apparent that little further was to be gained in prognosis or treatment by studying the conventional slide preparations in the laboratory. It was evident that in order to evaluate and treat the patient better something more must be known about the intimate growth properties of the cervical cancer cells themselves.

In recent years, the characteristics of squamous cells of the uterine cervix have received intensive study. The clinical interest in this endeavor has been widespread, and many clinicians have participated in combined clinical and laboratory studies.[1] This particular clinical interest has greatly facilitated the development of the field of exfoliative cytology.

From the clinical point of view, cervical squamous cell carinoma is excellent for a combined study between the research scientist and the clinician. Cervical material in all its phases is abundant and is obtained easily with either biopsy or smear technics. Cervical carcinoma can be followed through treatment and response with more accuracy than ever before. The panoramic changes of the cervix under the cyclic hormonal stimulations lend further interest to the research endeavor. Particularly in pregnancy, there is an added opportunity to study the cervix as it undergoes the proliferative reaction of this state.

From the Departments of Gynecology, Obstetrics and Pathology, Baptist Memorial Hospital, Jacksonville.
These investigations were aided by grants from the National Cancer Institute, National Institutes of Health, Public Health Service, including C-2719.
Read before the Florida Medical Association, Eighty-Third Annual Meeting, Hollywood, May 7, 1957.

To understand the histochemical changes occurring in the cells of squamous carcinoma of the cervix, it is first necessary to appreciate the following: the histochemical patterns of the normal cervix, the cervix with metaplastic epithelium, that with hyperplastic atypical epithelium, the cervix with intraepithelial carcinoma, and finally invasive squamous cell carcinoma.

We, therefore, first investigated the histochemical patterns of succinic dehydrogenase in each of the types of cervical epithelia mentioned, including pregnancy. Succinic dehydrogenase is a vital respiratory cellular enzyme found in all tissues. When neotetrazolium is incubated with cervical tissue under controlled conditions, the succinic dehydrogenase causes it to become a hydrogen acceptor. A deeply colored granular pigment called formazan is formed in the tissue with the enzyme. There is a close correlation between the sites of dehydrogenase activity and the proliferation and growth patterns of the cervical epithelium. The intensity of formazan deposition closely follows the growth transition of normal mucosa to metaplastic, to atypical epithelium and finally to intraepithelial carcinoma and frankly invasive cervical cancer. Since most of this activity is a reflection of the growth potentials of the basal layers of the cervical epithelium, the next histochemical step was to study the maturation factors in the upper layers of these various cervical tissues.

The localization of glycogen and protein-bound disulfide groups were the particular technics used. Glycogen is found in maturing squamous cells of the portio vaginalis; and disulfide groups are associated with keratinization and epithelial pearl formations. Glycogen has been reported to be absent in squamous cell carcinoma of the cervix.[2]

The specific histochemical reaction used to demonstrate glycogen was the periodic acid-Schiff technic after malt diastase digestion. It was found that the portio squamous epithelium has no glycogen staining in the basal layer, but the glycogen staining reaction increased with other evidences of maturation toward the surface epithelium. Less pronounced glycogen staining was found in the metaplastic epithelium. Many of the invasive squamous cell carcinomas studied showed some glycogen in the tumor cells, particularly in the areas of keratinization and epithelial pearl formation. This was most evident in the sections with well differentiated squamous carcinoma. Concomitantly, pronounced disulfide reactions were found in epithelial pearls and in regions of intracellular keratinization. This is a strong blue staining reaction.

In addition, parallel studies of phosphamidase activity, alkaline phosphatase reactions, protein-bound sulfhydryl groups, and lipid localization were carried out along with the other histochemical studies in cervical tissues.[3] Histochemical changes in the pregnant cervix were fascinating.[4] The growth patterns were greatly accelerated, and the dehydrogenase activity was particularly striking. Many of the sections resembled the malignant cervical tissue from nonpregnant patients in the amount and distribution of this respiratory enzyme. Of particular interest was the decidual reaction in the stroma and its intense dehydrogenase staining.

It is evident from these studies that there is no magic demarcation in cervical cells as they pass from the normal portio vaginalis mucosa through the varying phases to frankly invasive carcinoma. Rather, the cervical cells manifest a set of growth properties opposed to maturation properties. The nucleocytoplasmic and stromal changes are reflected by histochemical methods.

The specific histochemical changes and laboratory methods are not germane to this paper. It can be appreciated that the methods are time-consuming and a well trained technical staff is essential for their production. These evaluations of cervical tissue are obviously not now routinely offered. Nevertheless, it is not in the realm of the impossible that in the future they will give much help to the clinician in the diagnosis and treatment of cervical malignant disease.

Summary

In summary, these approaches to cervical cancer are new and have never been studied before. Newer technics and methods will grow from this understanding of the cervical epithelium in its various situations relating to cancer. These histochemical technics indicate that the chemical properties of these cells parallel their microscopic appearance and their growth potential: namely, that there is a gradual transition from normal mucosa to metaplastic epithelium, to a typical hyperplastic epithelium, to intraepithelial carcinoma to invasive squamous cell carcinoma.

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Abdominal Aortic Aneurysm

Harold C. Spear, M.D.
DeWitt C. Daughtry, M.D.
and
John G. Chesney, M.D.
Miami

With the decreased incidence of syphilis and the increasing life span, arteriosclerosis has become the commonest etiologic factor in the formation of aneurysms, and the abdominal aorta has replaced the thoracic aorta as the vessel most frequently involved. The purpose of the present report is to outline the clinical features of abdominal aortic aneurysms and to review the current concepts of management of this problem.

Clinicopathologic Features

Arteriosclerotic aneurysmal dilatation of the abdominal aorta is one of the degenerative cardiovascular diseases affecting the middle-aged and elderly. Frequently, however, it is an isolated problem unassociated with significant coronary artery disease, hypertension, or extensive peripheral obliterative vascular disease. Its importance lies in the fact that it is a progressive lesion leading to ultimate fatality from rupture and hemorrhage. The prognosis for the individual patient with an abdominal aortic aneurysm is impossible to determine, but a careful survey of a large number of patients with this condition revealed that approximately one third died within one year and two thirds within three and a half years of the establishment of the diagnosis.[1] Most of the deaths were attributable to rupture of the aneurysm.

Although rupture is generally unheralded by any premonitory symptoms or signs, recent studies have indicated that it is uncommon for an aneurysm measuring less than 7 cm. in diameter to rupture.[2] Certainly, any aneurysm larger than this should be regarded as a potentially fatal lesion.

The common symptoms of abdominal aortic aneurysm are pain, the presence of a pulsatile mass, and general malaise. Pain, when present, may be located in the lumbar area or abdomen, or both. It may be intermittent or steady, sharp or dull. Occasionally, radiation into the groin or scrotal area is observed. A pulsatile mass is of course most often noted by the thin person.

From the Daughtry-Chesney Clinic for Thoracic Surgery, Miami.

The only noteworthy sign on physical examination is that of a pulsatile, rounded mass which may be present in the midabdomen or to the left or right of the midline. It may be clinically indistinguishable from a pancreatic cyst or retroperitoneal neoplasm with transmission of aortic pulsations. A bruit may or may not be audible. The femoral pulses are ordinarily normal.

With the occurrence of rupture, the patient experiences an acute onset of excruciating pain commonly localized to the left lumbar and left flank areas but occasionally radiating into the left inguinal or scrotal region to simulate ureteral colic. The association, however, of a shocklike state with the pain and the presence of a pulsatile mass serve to clarify the diagnosis. Unlike dissecting aortic aneurysms, ruptured abdominal aneurysms are not ordinarily productive of changes in the femoral pulses.

Radiologic Examination

Generally the clinical diagnosis of abdominal aneurysm can be confirmed by posteroanterior and lateral roentgenograms of the abdomen which show the rounded aneurysmal mass with its characteristic "egg shell" calcification. On the lateral roentgenogram, the abdominal contents are shown to be displaced anteriorly by the aneurysm (fig. 1). Occasionally the configuration of the aneurysmal density or the "egg shell" calcification may be atypical (fig. 2). In these instances, translumbar aortography may be helpful in confirming the diagnosis (fig. 3).

Since the aneurysm arises below the renal arteries in approximately 95 per cent of cases and since this relationship can be most accurately determined at operation, translumbar aortography is not performed as a routine preoperative study. We believe, however, that aortography should be performed in the aged or poor risk patient to delinate the anatomic relationships of the aneurysm prior to operation. Although De Bakey, Creech and Morris[3] have brilliantly demonstrated the feasibility of resecting aneurysms which involve the renal arteries, this is an operation of such magnitude that it is generally inadvisable in the aged



Fig. 1.—Lateral roentgenogram showing anterior displacement of abdominal viscera by aneurysm.



Fig. 2.—Flat film of abdomen revealing aneurysm without usual calcification (case 1).

or poor risk patient. Translumbar aortography itself carries a low complication rate when properly applied.[4]

In the case of the ruptured abdominal aortic aneurysm, posteroanterior and lateral roentgenograms of the abdomen usually suffice to confirm the diagnosis. The aneurysmal mass with its mural calcification is observed to be surrounded and obscured by a homogeneous density representing the retroperitoneal hematoma, and the left psoas outline is partially or completely obliterated (fig. 4). Occasionally, it may be helpful to perform an emergency intravenous or retrograde pyelogram to clarify the diagnosis or rapidly to appraise renal function (fig. 5), but translumbar aortography is contraindicated both because of the difficulties of performing it and because of the increased hazard it incurs under these circumstances.

Treatment

During the past century, the surgical management of abdominal aortic aneurysms has progressed from proximal aortic ligation to internal reinforcement of the aneurysmal wall by wiring with or without concomitant electrocoagulation, to external reinforcement with cellophane wrapping. Although in many instances these measures have forestalled the occurrence of rupture, each of these procedures has been associated with its own inordinate train of complications, and none has resulted permanently in extripating the aneurysm.

In 1952, Dubost, Allary and Oeconomos,[5] applying the principles of aortic grafting which had been developed by Gross[6] in the surgical treatment of coarctation, first successfully resected



Fig. 3.—Aortogram showing irregular tortuous channel through aneurysm, which begins about 2 cm. below renal arteries (case 1).

an abdominal aortic aneurysm and re-established continuity by means of a homograft. De Bakey, Cooley and Creech[7] have now applied this technic to large numbers of patients with eminently satisfactory long term follow-up studies.

As the result of these pioneering efforts, elective resection of abdominal aneurysms with aortic homograft or prosthetic replacement can now be accomplished with remarkably low morbidity and mortality rates (figs. 6 and 7). In view of the excellent results attainable by operation and the poor prognosis which obtains in the untreated patient, it is urged that all patients with abdominal aortic aneurysms, whether or not symptomatic, should be evaluated for operative correction. Only those patients who exhibit renal insufficiency or severe associated cardiovascular or cerebrovascular disorders should be categorically denied surgical treatment.

The importance of early elective surgical correction is emphasized by the uniformly high mortality rates (30 to 50 per cent) associated with the surgical treatment of ruptured abdominal aneurysms. Although only an occasional patient will recover from the initial episode of rupture without operation, most patients survive for periods of six hours or more from the onset of symptoms of rupture. This brief survival period allows the performance of emergency surgical resection. One has only to deal with a few such cases to realize the immense advantages of early elective operation. Even the rare patient who survives the initial episode of rupture may subsequently present almost insuperable problems of therapy. In one such patient in the experience of one of us (H.C.S) there developed a large aorta-caval arteriovenous fistula following the rupture of the abdominal aortic aneurysm into the inferior vena cava. Although in refractory cardiac decompensation as the result of the fistula, he survived a difficult operative procedure during which the ruptured aneurysm was resected and a homograft inserted with concomitant repair of the site of rupture into the inferior vena cava. This complicated problem is cited to emphasize the desirability of elective operation early in the development of the disease, prior to the occurrence of rupture and its sequelae.

The following case reports are presented to illustrate some of the points raised in the preceding discussion.



Fig. 4.—Intravenous pyelogram in ruptured aneurysm (case 2) showing characteristic mural calcification surrounded by diffuse density which obliterates left psoas shadow.

Report of Cases

Case 1.—A 66 year old white woman was admitted to the hospital on Jan. 7, 1957 for investigation of complaints of pain in the left flank of five days' duration. The pain was of dull aching nature, without radiation



Fig. 5.—Retrograde pyelogram illustrating patency of urinary tract and its relationship to ruptured aneurysm (case 3).



Fig. 6.—Large abdominal aortic aneurysm as seen at operation. Tapes surround the common iliac arteries on each side.



Fig. 7.—Same case as in figure 4 following resection of aneurysm and insertion of aortic homograft, with nylon reinforcement of anastomoses.

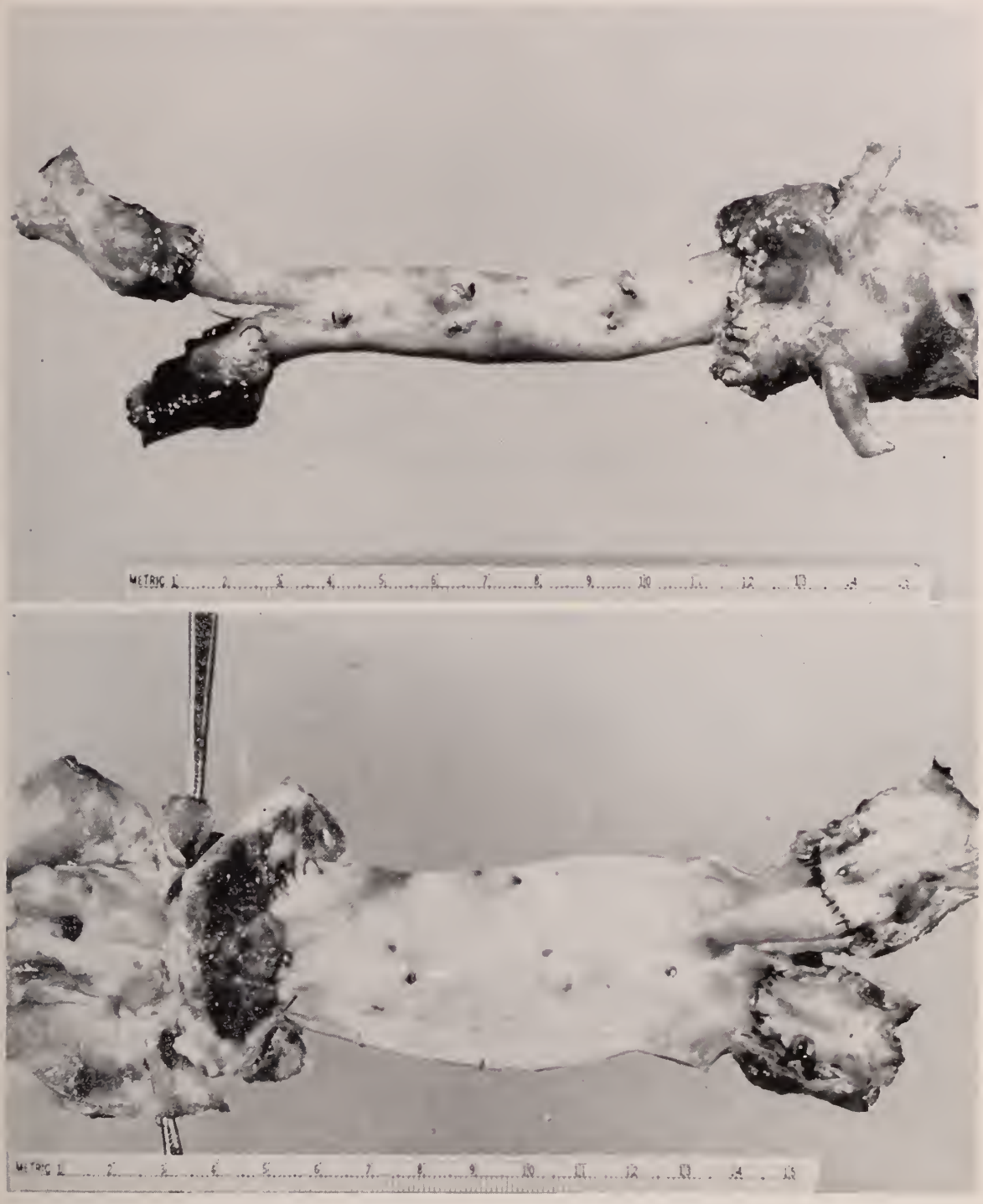


Fig. 8.—The unopened (A) and opened (B) specimen from case 2 showing the discrepancy in size between the graft and the host vessels, the relationship to the renal arteries (clamped in B) and the pronounced atheromatous degenerative changes in the host arteries.

and without associated gastrointestinal symptoms. The past medical history was significant in that she had been treated for an acute coronary occlusion in 1953 and had had significant hypertension prior to that time. Since the coronary attack, she had remained in good cardiac compensation without the use of cardiac drugs. She gave no history of angina pectoris.

On physical examination, the blood pressure was 160/100 in both arms. The lungs were clear. The heart was markedly enlarged. The cardiac rhythm was regular and there was a grade II basal systolic murmur. Abdominal examination revealed a large, fixed, rounded, nontender, left midabdominal mass which either pulsated or transmitted aortic pulsations. All peripheral pulses were palpable.

A complete blood count, urinalysis and blood chemistry studies were within normal limits. Electrocardiograms revealed evidence of left ventricular hypertrophy and old myocardial damage. Flat films of the abdomen confirmed the presence of a large left midabdominal mass

suggestive of an aneurysm but without the characteristic mural calcification (fig. 2). A complete gastrointestinal series and intravenous pyelograms revealed the mass to be retroperitoneal and extrinsic to both the intestinal and urinary tracts. Both kidneys functioned well. A translumbar aortogram confirmed the diagnosis of abdominal aortic aneurysm arising just below the renal arteries (fig. 3).

On Jan. 14, 1957, with the patient under general anesthesia, the abdomen was explored through a long left paramedian incision. A large bosselated abdominal aneurysm with two distinct thin-walled aneurysmal components was present, the larger and more superior of which arose just below the renal arteries and measured 15 cm. in diameter. The aortic bifurcation was uninvolved so that, following resection of the aneurysm, replacement with a straight abdominal aortic segment preserved by the freeze-dry process was accomplished.

Postoperatively, the lower extremity pulses were entirely normal throughout. Except for a transient episode of cardiac decompensation on the second postoperative day which responded promptly to medical therapy, the patient made an uneventful recovery.

This case is typical of the many abdominal aortic aneurysms which have been successfully resected at an elective operation. As in this instance, selected patients with serious complicating cardiovascular disease can be safely carried through the operation by careful medical management.

Case 2.—A 58 year old retired postal clerk was admitted to the hospital on Jan. 12, 1957 in profound shock. He had experienced the sudden onset of severe pain in the left flank with radiation into the left scrotal area several hours previously. The past medical history was significant in that he had been treated for a kidney infection in 1947. In addition, he had noted vague discomfort in the left flank during the month prior to admission.

Physical examination revealed a well nourished middle-aged white man who was cold, clammy and suffering acute pain in the left flank. The blood pressure was 70/0 and the pulse, 120. There was some abdominal guarding, but an ill-defined, deep midabdominal pulsatile mass which was not tender could be felt. Both femoral and both popliteal pulses were palpable.

The state of shock responded to intravenous fluid therapy followed by two units of blood. Flat films of the abdomen on admission revealed an ill-defined midabdominal density obliterating the left psoas outline. There was a calcific density just to the left of the upper lumbar spine which, in the light of the antecedent history of renal disease and the characteristic radiation of the pain, was thought to represent a ureteral calculus. Accordingly, intravenous pyelograms were performed which revealed both kidneys excreting dye without delay. On these pyelograms a definite abdominal aortic aneurysmal mass with mural calcification could be visualized. Surrounding the aneurysm a diffuse density was noted which was consistent with retroperitoneal extravasation of blood (fig. 4).

The patient was operated upon without further delay. An abdominal aortic aneurysm measuring 12 cm. in diameter was present, arising immediately subjacent to the renal arteries. The aneurysm had ruptured posteriorly into the retroperitoneal tissues, which were intensely congested with fresh and clotted blood. Although it was possible to resect the aneurysm and insert a bifurcation homograft which functioned satisfactorily, the patient remained in critical condition throughout the operation and expired 12 hours later of cardiovascular collapse with associated renal shutdown. Postmortem examination revealed the graft to be intact and the anastomoses patent (fig. 8) despite the extensive atheromatous degenerative changes in the host vessels.

This case illustrates the difficulties encountered once rupture occurs. Although it is generally possible to carry the critically ill patient through a successful operative procedure wherein the aneurysm is resected and continuity is restored by means of a homograft or plastic cloth prosthesis, the postoperative mortality rate from cardiovascular and renal complications is uniformly high. The most effective means of reducing the mortality rate at the present time is by the development of an awareness of the problem of abdominal aneurysm and by the institution of early elective surgical treatment.

Case 3.—A 67 year old white man was hospitalized on Feb. 14, 1955, three days after the sudden onset of severe midabdominal pain. Previously he was known to have hypertensive-arteriosclerotic cardiovascular disease and, in 1952, underwent right midthigh amputation for arterial insufficiency.

Upon admission, the patient was in mild shock, and a large pulsating midabdominal mass was palpable. Following supportive therapy including blood transfusion, his general condition improved although the abdominal mass grew larger. He was transferred to the service of one of us (H.C.S.) 48 hours later. The clinical diagnosis of ruptured abdominal aortic aneurysm was confirmed by flat films of the abdomen, and emergency retrograde pyelograms were performed to rule out urinary obstruction, in view of a history of no urinary output over the preceding 24 hours (fig. 5). Operation was carried out immediately thereafter. A large abdominal aortic aneurysm which had ruptured posteriorly into the retroperitoneal tissues was resected, and a bifurcation homograft was inserted. Except for an initial period of oliguria with associated nitrogen retention, the postoperative convalescence was uneventful.

As was previously mentioned, most patients survive for more than six hours following rupture of an abdominal aneurysm. This is related to the universal presence of a laminated organizing mural thrombus which, together with dense perianeurysmal inflammatory reaction, tends to avert free rupture and to result in a sinuous pathway of extravasation. Case 3 illustrates the occasional prolonged interval which may be available following rupture, during which salvage may still be accomplished.

Summary

The problem of abdominal aortic aneurysm is discussed from the standpoint of pathologic physiology, prognosis, diagnosis and surgical treatment. Three cases are reported to illustrate different aspects of the discussion.

In view of the rapid progression of the majority of these lesions to fatal rupture, and in view of the current low mortality rate for elective surgical treatment, it is recommended that all patients with abdominal aortic aneurysms be evaluated for operation as soon as the diagnosis is made. Once

rupture has occurred, operative intervention, although offering virtually the only hope for survival, is fraught with at least a fourfold increase in mortality rate.

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Gastroschisis

Report of a Case

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IMMOKALEE

Gastroschisis is a congenital anomaly in which the abdomen remains open, with viscera protruding. This malformation occurs so rarely that Moore and Stokes,[1] in reviewing the literature, found only five authenticated cases in living newborn infants. In three of these cases surgery was attempted, with a successful result in one. These authors reported two cases, in both of which the infant died.

This anomaly of the abdominal wall consists of a large eviscerated mass of discolored intestines of leathery consistency. The intestines are often embedded in a rather dense gelatinous matrix. The defect is extraumbilical, as the insertion of the umbilical cord is normal. No covering sac or its ruptured remnants is present at birth. The absence of a sac results in enlargement and thickening of the intestines, with cyanosis, injection and adhesions. The peritoneal cavity in such cases is usually small, and malrotation of the intestines is a frequent feature.[1] Hardaway[2] attributed the high mortality to massive disproportion between the volume of the eviscerated mass and the capacity of the abdomen, infection due to the lack of a protective covering as found in an omphalocele, and the poor condition of the bowel wall.

The rarity of gastroschisis and the gravity of the problem encountered warrant presentation of an additional case.

Report of Case

An 18 year old, white, transient, maternal, Spanish woman, gravida III, Para II, was first seen on March 5, 1957. She was in labor. Her antepartum care had been nil except for one visit to the County Health Department Clinic when it was reported that the County Health doctor had refused to allow her to be delivered by a midwife. The reasons were poorly understood by the patient, who spoke only broken English. The last menstrual period was unknown. There was no contributory history.

Examination revealed a thin but well developed, well nourished white woman. The head, eyes, ears, nose, throat, chest and heart were within normal limits except for caries. The temperature, pulse rate, respirations and blood pressure were normal. Examination of the abdomen revealed a pregnant uterus extending half way between the umbilicus and the xiphoid process. Uterine contraction occurred every five to 10 minutes. The position was judged as breech. Rectal examination revealed the cervix to be 3 cm. dilated, and a breech presentation LST was confirmed. The extremities showed varicose veins but no edema. The urine was negative for sugar and protein, and the hemoglobin was 10 Gm.

COURSE OF LABOR.—The fetal heart tones ranged from 120 to 156 per minute throughout the course of labor. The breech presentation later appeared as an incomplete breech double footling presentation. Upon the appearance of both feet at the introitus, they turned cyanotic immediately. Spontaneous rotation began in a reverse manner; if it had progressed in its spontaneous attempt, the chin of the infant would have become impinged behind the symphysis pubis of the mother. This rotation was manually halted and reversed. Because of the cyanosis, mild traction was placed on the thighs, which were then at the introitus. Only partial descent occurred when it became obvious that there was an obstructed labor. The back of the infant was quickly inspected by palpation and a diffuse soft tissue bulge was noted over the lumbar area. It was apparent that this soft tissue mass was not the cause of the obstruction because it was too soft, diffuse and small.

Cyanosis deepened and involved the buttocks now presenting. The infant's abdomen was quickly palpated, and it was noted that a large pendulous soft tissue mass filled the posterior birth canal. Blood began to flow from the posterior canal. Upward pressure on the soft tissue mass combined with traction upward and outward on the buttocks brought the mass from the introitus, and the second stage of labor was consummated in the usual manner. Rotation and delivery of the first shoulder appearing was followed by rotation and delivery of the remaining shoulder beneath the symphysis pubis with the back of the infant hyperextended over

the symphysis of the mother and pressure exerted on the inferior maxilla. The placenta, either spontaneously or traumatically detached from the infant, delivered immediately and spontaneously. The total time of delivery was three minutes from the first sign of cyanosis. The estimated blood loss was 300 cc.

The infant died two hours and 10 minutes after delivery.

GROSS INSPECTION.—The infant weighed 4 pounds.

Placenta.—The placenta was free of scars and intact. It was smaller than normal. The cord measured 5 cm. This probably accounts for the intrapartum hemorrhage and the immediate delivery to the placenta. The cord was small, had a velamentous attachment to the placenta and consisted of a thin membrane enveloping a small amount of Wharton's jelly and three visible vessels. Two of these were seen to arise out of the pelvis of the infant and one to enter the liver.

Head and Chest.—Respirations were shallow, irregular and 10 to 20 per minute. There was no cyanosis of the upper portion of the trunk or of the face. The heart rate was regular and 140 per minute.

The skull and face bones were compressed on the right surface. The compression apparently was incurred from the fetus having lain in one position for a long time. The chest was well formed and normal.

Abdomen and Viscera.—There was a thick serous membrane over the viscera. No skin or muscles had formed from the costal margins superiorly to the symphysis below or between the anterior axillary lines. The arrested skin growth was sharply demarcated. The liver was large and bluish in color. The lobes were indentified. No gallbladder was demonstrable, but a large common duct was seen communicating between the small intestine and the liver. The stomach was small and retroperitoneal. It was immobile. The small intestine measured 2 feet and was retroperitoneal and fixed. The colon was all retroperitoneal and fixed except for the cecum and the most distal portion (10 cm.), which was extraperitoneal, open and inverted revealing mucosal folds. The appendix was identified as a small button-like appendage attached to the cecum by a thin fibrous band. The appendix was mobile and extraperitoneal. The spleen, kidneys and pancreas were small and located in the correct anatomic position. The kidneys and the pancreas were retroperitoneal. The adrenal glands were identified and were normal in size and position. The anal area was imperforate. There was slight invagination but no dimpling.

Genitourinary Tract.—The bladder was well formed, and a short, flat, membranous tube 1 cm. wide and 2 cm. long was protruding from the anterior-inferior border. No gonads were demonstrable. The genitalia were absent except for two dark pendulous folds of skin which protruded from the external surface of the lateral perineum. They contained no gonads and resembled folds of labia majora.

Extremities.—The legs were bowed and crablike in posture. The knee and ankle joints were rigid. The legs could not be moved, and the hips were fixed.

Back.—There was a large diffuse mass over the lumbosacral area which was fluctuant and apparently contained a small amount of fluid.

The postpartum course of the mother was uneventful.

Summary

A case is reported in which the characteristic features of gastroschisis were present. The infant lived only two hours.

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Box 226.



Choledochal Cyst

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The most important abnormality of the liver and biliary passages which necessitates surgery in the young infant and child is chronic jaundice caused by biliary obstruction due to atresia of the bile ducts in the early months of life. A less common condition is choledochal cyst. A unique case in which atresia of the bile ducts was associated with choledochal cyst was reported by Ripstein and Miller.[1] Choledochal cyst also occurs in adult life. This condition is more correctly known as idiopathic dilatation of the common bile duct. This is a congenital lesion in which an enormous dilatation of the lower part of the extrabiliary duct system occurs, and the etiology is often obscure. In some cases there is a stenosis, a valve-like fold in the ampulla of Vater or lower common bile duct, or angulation in the lower part of the common bile duct. In other cases there is no abnormality of the junction of the common bile duct with the duodenum. The duct may be as large as a grapefruit or an orange, or in exceptional cases it may be larger. Once the dilatation has occurred, its weight makes it hang to one side and angulate the lower end to produce further obstruction. Approximately 200 cases of this condition had been reported in 1953, and cases continue to be added. An artist's depiction of this condition is seen in figure 1.[2,3]

Pathology

The chief finding is dilatation of the common bile duct and this occurs as a marked rounded enlargement of all or part of the choledochal duct. This dilatation may involve only the common duct, or the juncture of the cystic, hepatic and common ducts may be involved. Only one duct, therefore, may be found entering the cyst (the superior part of the choledochus); or the hepatic and cystic ducts may enter the cyst at two different points, and their openings may be separated by a distance of 2 or 3 cm. The cyst is joined to the duodenum by the lower part of the common duct. Occasionally, the enlargement involves so distal a part of the common duct that the choledochal cyst is entered directly by the pancreatic duct. The localized enlargement of the biliary ducts is distinguished from dilatations which occur in purely obstructive conditions of the inferior common duct, as when the common bile duct is obstructed by carcinoma of the head of the pancreas in the adult. In these conditions the distention of the bile duct involves the whole biliary tree; the common bile duct is hardly ever bigger than a small intestinal loop, and the gallbladder is greatly dilated. In choledochal cyst the gallbladder is rarely enlarged.

The cyst is very large and it may contain 1 to 2 liters of bile. In a case reported by Reel and Burrell[4] the cyst contained 8,000 cc. of bile. The larger cysts are usually found in older patients, but this is not a constant relationship. The wall of the cyst is tough and measures 2 to 4 mm. in thickness. It is made up of dense connective tissue, and the elastic substance and smooth muscle are often absent. Epithelium is usually lacking in the lining of the cyst. The lining may be irregular and roughened, and there may be dried bile pigment deposits over the lining; at times pus is present with an exudate indicating secondary infection. The dilatation of the cystic and hepatic ducts and the gallbladder which occurs is minimal compared to the enormous size of the common bile duct. The liver is often enlarged and cirrhotic, and in a few cases the intrahepatic ducts are greatly enlarged. Microscopic examination of the liver reveals cirrhosis with an increase in periportal connective tissue, overgrowth of bile capillaries and rarely biliary stasis. Infection is frequent, and white blood cell infiltration of the portal areas may be present. There may be marked cholangitis, and pus may be found in the bile duct.

Etiology

Obstruction has been found in many cases, but the enormous dilatation of the common duct points to a local defect in the wall of the common duct which permits it to dilate enormously. The following theories have been advanced:

1. The common duct takes an anomalous course through the lower duodenum which produces a "kink" in the duct and causes biliary obstruction.

Read before the Southern Surgical Association, Hot Springs, Va., Dec. 5, 1955.

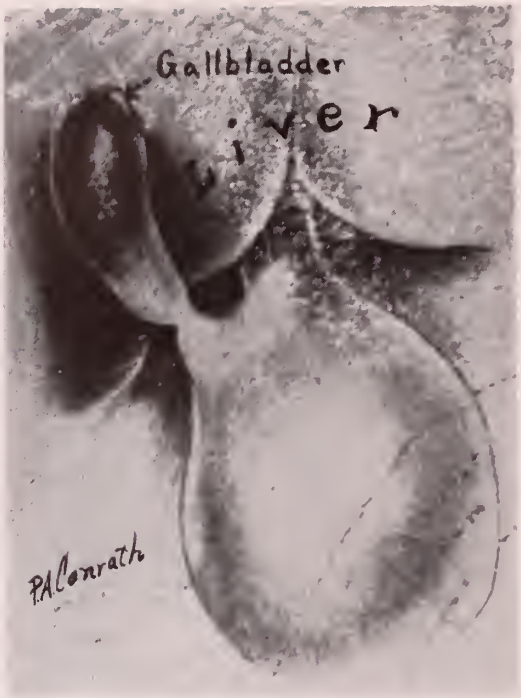


Fig. 1. — Choledochal cyst.

2. Congenital stenosis of the lower part of the choledochus.

3. Achalasia of the sphincter of Oddi.

4. Congenital weakness of the common bile duct permits dilatation under normal intraductal pressure. This condition is comparable to congenital idiopathic hydronephrosis.

5. The common bile duct lacks the ability to contract and bulges out locally after an obstruction in the lower part of the duct.

6. Others believe that the cyst is of congenital origin and is in reality an anomalous malformation, and that the valve which has been described is secondary to this cyst.

7. The cyst is due to diverticulum of the common duct such as the one which produces a ventral pancreas.

None of these explanations explain all cases of choledochal cyst, but many of the cases are explained by one or more of these various theories. It is possible that there may be a group of conditions which are similar, but whose etiology is different. The most likely theory seems to be that which postulates a congenital weakness of the ductal wall which permits dilatation only when obstruction occurs.

Symptoms and Signs

The clinical picture is marked by the triad of abdominal pain, tumor and jaundice. Pain occurs in 65 per cent of the cases. It was absent in the first case reported here until two days prior to operation. Usually, it is present in the epigastrium or in the right upper quadrant. The pain is not severe; at times it is accompanied by nausea, but vomiting rarely occurs. There is no connection between the severity of the pain and the size of the cyst. In about 90 per cent of the cases abdominal tumor is present. A mass is felt just below the liver area in about half of the cases. The cyst may be displaced to the left by an enlarged liver. Often, the cyst has a solid feel on palpation, and the tightness and the size of the cyst may vary on different examinations. It has been noted that several hours following a meal the cyst becomes larger and firmer, probably because of increased biliary secretion during this time.

Jaundice is present in about 90 per cent of the cases. Highly colored urine and acholic stools have been present at times in one third of the cases. Fever is often present and is probably due to cholangitis or hepatitis. The fever range is from 101 to 102 F., but in occasional cases it has been as high as 104 F. Any one of the triad of symptoms may be present alone, or may be present in combination with the other symptoms. The order of appearance of these symptoms varies. The average duration of symptoms is about three years before the choledochal cyst is found. The symptoms tend to be intermittent, and the general course of the disease is one of exacerbations and remissions, but one or more of the symptoms may have been constant. Females are affected about four times as commonly as males.

Differential Diagnosis

Echinococcus cyst of the liver may be confused with this condition, but usually in echinococcus disease there is a mass in the liver which does not markedly affect the patient's health. The swelling in echinococcus cyst is often the only complaint, but if infection occurs, fever and leukocytosis are present. In a very large echinococcus cyst jaundice may be present. An echinococcus cyst tends to become progressively larger or remain stationary, and the choledochal cyst usually varies in size especially after eating. An echinococcus cyst of the liver moves with respiration and seldom causes pain. Negative complement-fixation tests are helpful in ruling out an hydatid cyst, and the limited geographic distribution of echinococcus disease is also helpful in differential diagnosis.

Gallstones are rare in children, and roentgen examinations of the gallbladder are helpful in making or excluding this diagnosis. Cholelithiasis in children is usually due to a hemolytic blood dyscrasia, and the absence of a hemotologic condition makes a diagnosis of gallstones unlikely.

Abdominal carcinoma in children usually is progressively and rapidly fatal. In a patient, therefore, who has had an abdominal mass for more than a year and is still well nourished and active, it is unlikely that a neoplasm will be present. Neoplasm may be ruled out if the mass beneath the liver has frequently and definitely varied in size.

Congenital atresia of the bile ducts is usually excluded by the age incidence of these two conditions. The mean age of patients with congenital atresia of the bile ducts is from one to three or four months. The patients who cannot be helped by operation usually die in less than a year. Only 5 per cent of choledochal cyst patients have had symptoms prior to six months of age. The patient with choledochal cyst tends to be considerably older than the patient with congenital atresia of the bile duct.

Treatment

The outcome of operation depends upon how soon the surgeon recognizes the nature of the choledochal cyst. To quote Gross:[5] "It is, therefore pertinent to emphasize that the surgeon must be familiar with the pathology of this condition, for only then can he quickly recognize the lesion and rapidly promote drainage of the biliary system into the intestine which has proved to be so efficacious in curing these individuals."

External drainage of the common bile duct cyst has resulted in very high mortality rates.

Excising these cysts should not be attempted. Abdominal tapping should be avoided because of the danger of causing the cyst to leak into the general peritoneal cavity and because of the danger to other viscera. Cholecystoduodenostomy or cholecystogastrostomy may be performed, but the treatment of choice is to anastomose the cyst to the duodenum. A cystostomy may give an added safety factor. Connection of the cyst to a side arm of the jejunum in a Roux Y procedure is unnecessary, according to Gross.[5] Attar and Obeid,[6] however, collected nine cases in which the cyst was anastomosed to the jejunum by means of the Roux Y procedure with no mortality or cholangitis. In contrast, they stated there is a 24 per cent mortality with choledochojejunostomy.

Results of Treatment

The mortality in 52 children was 69 per cent, but in a group treated by anastomosing the biliary tract and intestine the mortality was only 9 per cent.

Report of Cases

Case 1. — An 11 year old Negro girl was admitted to Brewster Hospital on April 18, 1955 complaining of jaundice of 48 days' duration. Jaundice which began seven weeks before admission, progressively increased in intensity. Vomiting accompanied by fever occurred for one week at the onset of the illness. The child had vomited an adult Ascaris lumbricoides worm on one occasion. Blood of unknown color had been passed in the stool three times since the jaundice appeared. Epistaxis occurred three days before admission. The stools had been white and the urine dark since the icterus began.

The child was born at home and weighed 6½ pounds at birth. Jaundice had not been present before this illness, but one of the mother's 10 siblings had had jaundice as a baby. Two siblings were born dead. One sibling died at the age of 11 months of unknown cause.

The patient was a well developed and nourished child whose sclerae were yellow. The temperature was 97 F. and the pulse rate 100. The skin showed scratch marks, and the nostrils contained dry blood. The liver was felt 3 to 4 cm. below the thoracic cage in the anterior axillary line, the midclavicular line and the midepigastric line. On a subsequent examination, the mass in the midclavicular and midepigastric line was not believed to be the liver, and the possibility of its being the gallbladder was considered.

The admission urine was bile-stained and cloudy. The albumin was 1 plus, and there was a trace of sugar; the specimen was positive for bile. Many coarsely granular casts were present. Four and seven days after admission the urine was negative for urobilinogen.

The leukocyte count was 5,400 with 64 per cent polymorphonuclear neutrophils and 36 per cent lymphocytes. There was a 2 per cent eosinophil count. The hemoglobin was 10.3 Gm. on admission and 9 Gm. four days after admission. There was a 4 per cent reticulocyte count, platelets numbered 252,000, and no nucleated red blood cells were seen. On admission, the blood showed 90 per cent sickling in eight hours, and four days later 100 per cent latent sickling was noted. The mother's blood showed no immediate sickling and 1 per cent latent sickling.

The coagulation time was four minutes and the bleeding time one and one-half minutes. The prothrombin time was 14 seconds with a control of 13.5 seconds. Seven days after admission, the agglutination for typhoid O and brucellosis was negative, and 10 days after admission agglutinations were positive in a 1:40 dilution for typhoid O.

The blood sugar was 89 mg. per hundred cubic centimeters. The reaction to the van den Bergh test was 7.7 units direct and 10.8 units indirect. Eight days following admission, the van den Bergh reaction was 11.7 units direct and 15.9 units indirect. Fifteen days after admission, the direct van den Bergh reaction was 11.9 units and the indirect reaction 17.2 units. The alkaline phosphatase was 13 Bodansky units seven days after admission, 1 Bodansky unit 16 days after admission and 21 King-Armstrong units in another laboratory 19 days after admission. The icterus index, 16 days after admission, was 76 units. Twenty days following admission, the blood cholesterol was 286 mg. per hundred cubic centimeters, and the serum protein was 8 Gm. (3.90 Gm. of albumin and 4.1 Gm. of globulin). The thymol turbidity was 4 units, the thymol flocculation at 18 hours was negative, and the thymol turbidity ratio at 18 hours was 103 per cent. The serum showed inhibited flocculation of a known positive hepatitis case.



Fig. 2. — This roentgenogram shows barium entering the choledochal cyst from the jejunum.



Fig. 3. — The barium was still present in the cyst at the end of two hours.

The stool was negative for bile four days after admission, and two stools examined 11 days after admission were negative for bile; one stool was negative for ova and parasites. Examination of the gastric juice was negative for bile.

Flat films of the abdomen and chest were negative. The gallbladder was not visualized after the administration of Telepaque. The gallbladder and hepatic ducts were not visualized by Cholografin. Roentgenograms of the stomach and duodenum were negative. A roentgen study of the right and left tibia showed no evidence of disturbance of growth, periosteal reaction, or localized bone disease.

Course in Hospital.—A few days after admission, the child had epistaxis which continued during the day, and it was thought that she lost about 250 cc. of blood. The nasal bleeding was controlled by cauterization and packing, and transfusions were given.

One month after being admitted to the hospital and four days after surgical consultation, a U-shaped transverse incision was made across the upper abdomen. There was an enormous cystic dilatation of the common bile duct which measured 20 cm. in diameter. This cyst pushed the liver to the right and pushed the stomach to the left. The duodenum was probably behind and inferior to the cyst and was not readily visualized. Filmy adhesions between the stomach and the cyst were dissected away. As this dissection was continued, the serosa was stripped from the stomach in a small area, and the dissection was stopped. A loop of jejunum was grasped about 12 inches beyond the ligament of Treitz, and the jejunal serosa was sutured to the serosa of the cyst with interrupted sutures of 0000 black silk. The cyst and jejunum were then opened, and the full thickness of these structures was sutured together by a continuous suture of 00 chromic atraumatic gut. This was carried anteriorly as a Connell stitch. The anastomosis was completed by approximating the anterior serosal surfaces with 0000 black silk. A piece of omentum was sutured over the anterior suture line. The abdomen was closed in layers.

Following the operation, the temperature ascended to 103 F., and the pulse rate was ranging between 130 and 140. It was feared that the suture line might be leaking. Three days following the operation, however, the patient began to pass flatus and took fluids and a soft diet by mouth. Eight days following the operation, the temperature was elevated to 102.8 F. rectally and again 11 days following the operation. Twenty-five days after the operation, a roentgenographic examination of the upper intestinal tract showed the barium to enter the cyst and be retained there for four hours (figs. 2, 3 and 4). This influx of barium into the cyst may explain the occurrence of



Fig. 4. — Barium was still present at the end of four hours. The outlines of the enormous cyst are seen.

cholangitis after anastomosis of the cyst to the upper intestinal tract. One author stated that if the anastomotic opening is made large, there will be no cholangitis. There has been no cholangitis in this patient in the six months' follow-up period. Aspiration of the wound obtained 4 cc. of old dark blood which was negative on culture. The temperature was frequently elevated during the postoperative period, but 22 days after the operation the temperature descended to normal and remained so until the patient's discharge on June 21. The icterus index gradually descended to normal. The child was treated by hematinics, Terramycin, streptomycin, penicillin and testosterone propionate during the postoperative period.

The patient was seen in the office nine days following her discharge; she had no jaundice and weighed 85½ pounds. She was seen again a month later and had gained 4¾ pounds. Her appetite was good. She had had no abdominal pain, and no jaundice was present. The incision was well healed. Five months following discharge, her weight was 99¼ pounds, and her general health and appetite were excellent. Figure 5 shows the incision used and the general state of health six months following the operation.

Case 2.—The second patient, from the practice of Dr. Frederick J. Waas, was a nine year old white child who was admitted to St. Vincent's Hospital on September 13, 1950 complaining of abdominal fullness and loss of appetite.

The mother stated that the child was jaundiced at birth and remained jaundiced for 10 to 14 days. The patient was well until one year prior to admission when a generalized pruritus with no eruptions developed. The pruritus usually lasted about one week at a time. She had been having episodes of pruritus every month for the year preceding admission. During one of these episodes, she was seen by a doctor who examined her carefully and found her liver to be enlarged. Three months prior to admission, the child had an episode of pruritus during which her skin and eyes became yellow. The urine during this period was dark, but there was no change in the color of the stools. The child had frequently had a "stomach-ache" and told her mother that she had to vomit. She never vomited, however, until six days before admission. The episodes of pruritus had been accompanied by fever. The last episode occurred six days before admission. At that time, she was noted by her teacher to be scratching herself constantly in school. A little later she became nauseated and vomited a material whose color could not be determined. A weight loss of about 5 pounds had occurred in the 10 months preceding admission. Her weight had fluctuated markedly. During the episodes of pain in the right upper quadrant of the abdomen, the patient had had difficulty in breathing. One year before admission, she had had inflammation of the ear, which was treated by an otolaryngologist.

On physical examination, the patient was noted to be a moderately well nourished and moderately well developed white female child who was in no apparent pain. The pulse rate was 84, and the respirations were 18. The sclerae were yellow. There was a mass 3½ finger breadths below the right costal margin. This was nontender and blunt in feel, and the relative area of liver dullness extended down to this level. The skin was gray, and there were several excoriated areas over both buttocks.

The red blood cell count was 4,750,000 with 6,750 white blood cells, and there were 52 per cent polymorphonuclear neutrophils, 4 per cent eosinophils and 44 per cent lymphocytes. The fragility test and the prothrombin time were normal. The cephalin flocculation test gave negative results after 48 hours. The blood sugar was 96 mg. The total protein was 7 Gm. per hundred cubic centimeters. The icterus index was 6. There was 0.2 mg. of bilirubin per hundred cubic centimeters. Examination of the urine gave negative results. The urobilinogen was negative.

Roentgenograms of the chest gave negative evidence. Roentgenographic examination of the gallbladder, after the oral administration of Priodax, showed nonfunction of the gallbladder. Examination of the upper gastrointestinal



Fig. 5. — This photograph shows the incision used and the general appearance of the patient six months following the operation.



Fig. 6. — Flattening of the first portion of the duodenum with displacement of the duodenum downward and toward the left, suggesting a mass in the right upper quadrant.

tract revealed the esophagus and stomach to be normal, but the duodenum was flattened in its first portion and it was displaced downward and toward the left, suggesting a mass in the right upper quadrant (fig. 6). The stomach emptied normally, and within three hours the meal had reached the splenic flexure. There was no displacement of the hepatic flexure or proximal transverse colon.

Twelve days following admission, the abdomen was opened by means of an upper right rectus incision. There was a smooth spherical mass about the size of a grapefruit, measuring 16¼ cm. in diameter, located in the hepatoduodenal ligament. The mass was attached above to the hilus of the liver and below to the first portion of the duodenum. There was no adherence of the mass anteriorly, and the lesser peritoneal cavity could easily be entered through the foramen of Winslow. Aspiration of the mass showed it to contain cloudy green bile with numerous white threads. The liver was enlarged and firmer than normal. No common duct or hepatic duct was identified. The stomach and duodenum were grossly normal, but the gallbladder was represented by a small fibrous mass 2½ cm. in its greatest dimension. The cyst was anastomosed to the duodenum using 0000 cotton for the seromuscular sutures and continuous 0000 chromic catgut for the inner sutures. A No. 16 T tube was introduced through the wall of the cyst, and one of the limbs of the tube was left in place through the anastomosis. The abdomen was closed in layers, using interrupted 0000 cotton for peritoneum, fascia and skin. A Penrose drain was placed in the wound.

A biopsy specimen of the wall of the cyst consisted of a single, greenish-gray, irregular piece of tissue 3 cm. in its greatest dimension. Sections showed fibrous tissue with large numbers of inflammatory cells, including neutrophils and extravasated red cells. No definite epithelial surfaces were identified. The pathologic diagnosis was: Wall of choledochus cyst, showing benign inflammatory tissue.

Four days following the operation the drain was removed. Fifteen days following the operation, the irrigation of the T tube produced thin bile. The patient was discharged from the hospital on October 14 with the T tube still in place. The T tube was removed 31 days following the operation.

Since the operation, the patient has had, about every nine to 12 months, an episode of pain in the right upper quadrant of the abdomen. This pain usually subsides without any treatment. In 1953 the pain was severe and accompanied by fever, and she was given an antibiotic and antispasmodic with relief of symptoms. These episodes of pain usually last four to five days. She has not been jaundiced since the operation. She had not had an episode of abdominal pain in the year preceding October 1955.

Summary

Two cases of choledochal cyst are presented. The pathology, etiology, differential diagnosis and treatment of this condition are reviewed.

References

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2. Graham, E. A., editor: Surgical Diagnosis. By American Authors, 3:459;1082, Philadelphia, W. B. Saunders Company, 1930.
3. McWhorter, G. L.: Congenital Cystic Dilatation of Common Bile Duct, Arch. Surg. 8:604-626, 1924.
4. Reel, P. J., and Burrell, N. E.: Cystic Dilatation of Common Bile Duct, Ann. Surg. 75:191-195 (Feb.) 1922.
5. Gross, Robert E.: The Surgery of Infancy and Childhood, Its Principles and Techniques, Philadelphia, W. B. Saunders Company, 1953.
6. Attar, S., and Obeid, S.: Congenital Cyst of Common Bile Duct: Review of Literature and Report of Two Cases, Ann. Surg. 142:289-295 (Aug.) 1955.

2000 Park Street.

Benign Myalgic Encephalomyelitis

Syndrome Mimicking Anterior Poliomyelitis

Irvin M. Greene, M.D.
Miami Beach

The syndrome known as benign myalgic encephalomyelitis is so named mostly for expediency. Other names that have been advanced are Akureyri disease[1] or Iceland disease because it was first described in Akureyri, Iceland, by Sigurdsson and others[2] in 1950. Since then outbreaks have occurred in several towns in England, a recently described one being that at the Royal Free Hospital in London in 1955. The outbreaks in Florida at Tallahassee in 1954 and later in Punta Gorda seem to be nosologically similar to the English entity. Because of its apparently recent arrival in southern Florida, I wish to describe a case of this nature, which may perhaps alert the practitioners of this area for further possible incidence of the disease.

Report of Case

A 47 year old Comptometer operator and former ballet dancer was admitted to Mt. Sinai Hospital of Greater Miami on Aug. 2, 1956, because of sore throat, vague malaise and dizziness. On the second day of hospitalization she was still afebrile but drowsy, and a dry irritative cough developed. A diagnosis of infection of the upper part of the respiratory tract was made.

After five days of treatment with mostly aspirin for a slight elevation of temperature and symptomatic medication, the patient improved. Then on August 10, nine days after admission, a painful swelling over the left parotid gland at its infra-auricular portion appeared. This vanished the following day, but was followed by nausea, vomiting and a temperature of 102 F. There was tenderness along both parotid glands and the postcervical glands, but no evidence of mumps was observed. At this time headache, nuchal rigidity, pain on movement of the neck, and Kernig's sign were noted. Lumbar puncture was performed, and although this relieved the headache, the cerebrospinal fluid was normal except for a slight traumatic bloody tinge. The protein was 50 mg. per hundred cubic centimeters, and the fluid was not remarkable for any other positive findings in view of the traumatic puncture.

On the tenth day of hospitalization, paresis of both legs was present. This involved the extensors of the thighs and calves of both legs. Nuchal rigidity became less pronounced, but a certain amount of nuchal resistance was present. The muscles of the back and chest were painful and tender. Tendon reflexes were brisk bilaterally. No ankle clonus, Babinski or Hoffman sign could be elicited. The patient had frequent crying spells, which was "unlike her usual self."

After a neurologic consultation, it was decided to transfer the patient to Children's Variety Hospital for treatment of anterior poliomyelitis. At that hospital on August 12 another lumbar puncture was performed, with negative findings including a protein content of 25 mg. and no pleocytosis. By this time an improvement in the paresis of both legs was observed. The resident staff at Variety Hospital stated that the disease was not poliomyelitis, and arrangements were made for the patient's return to Mt. Sinai Hospital.

The further course of the illness after readmission of the patient to the hospital was characterized by six days of low grade fever, abdominal cramps and diarrhea for two days. On August 17 she was afebrile. There were, however, complaints of weakness of the legs and some difficulty in walking. She was discharged from Mt. Sinai Hospital on August 18. At home she again had a mild fever and severe weakness of the legs, whereupon the local physician hospitalized her at Doctor's Hospital. The course there was one of gradual subsidence of the fever and general improvement. Following her discharge she returned to work. Her only complaint at this date is some residual weakness of her legs.

Virus studies were made on two separate specimens of blood which were sent to the special virus laboratory at Variety Hospital during the first few days of illness, and then again during convalescence. Evidence of the following virus diseases was looked for, but was not found: lymphocytic choriomeningitis, mumps, eastern equine and St. Louis equine encephalitis, APC virus and Coxsackie group B 1-5. Agglutination tests for infectious mononucleosis and atypical pneumonia also gave negative results. Blood culture and cephalin flocculation tests likewise gave negative results.

Comment

The Guillain-Barré syndrome was considered because of the bilateral nature of the paresis; however, the usual high protein content of the cerebrospinal fluid was lacking. Lymphocytic choriomeningitis and a meningitic form of infectious mononucleosis could not be supported clinically or by laboratory tests. It is possible that there are several as yet undifferentiated entities which simulate anterior poliomyelitis. The case described, however, corresponds in important respects to the outbreaks described in London in 1955, in Berlin in 1954,[3] and in Iceland in 1948-1949. The possibility of this disease being nonparalytic poliomyelitis is negated by the cerebrospinal fluid and the onset of paresis.

Summary

A symptom complex recently delineated[4-9] and simulating anterior poliomyelitis is exemplified by the case described. It is the purpose of this presentation to direct attention to a syndrome relatively new in this area in order to stimulate further investigation into a disease which may be confused with anterior poliomyelitis.

From the General Practice Section of Mt. Sinai Hospital of Greater Miami, Miami Beach.

	Laboratory Studies								
Date	Red Blood Cells	Hemoglobin	White Blood Cells	Polymorphonuclears	Band Cells	Lymphocytes	Monocytes	Eosinophils	Basophils
Aug. 2	4.1	12.15	9,950	61	1	20	5	1	2
Aug. 5	4.2	12.6	5,900	56	5	29	6	3	1
Aug. 9	4.4	12.6	6,600	43	14	40	0	3	
Aug. 11	4.3	13.4	14,500	80	13	3	2		

References

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3. Sumner, D. W.: Further Outbreak of Disease Resembling Poliomeylitis, Lancet 1:764-766 (May 26) 1956.
4. Acheson, E. D.: Encephalomyelitis Associated with Poliomyelitis Virus; An Outbreak in a Nurses' Home, Lancet 2: 1044-1048 (Nov. 20) 1954.
5. McAlpine, D.; Buxton, P. H.; Kraemer, M., and Cowan, D. J.: Acute Poiiomyelitis with Special Reference to Early Symptomatology and Contact Histories, British M. J. 2:1019-1023 (Dec. 27) 1947.
6. Macrae, A. D., and Galpine, J. F.: Illness Resembling Poliomyelitis Observed in Nurses, Lancet 2:350-352 (Aug. 21) 1954..
7. Pellew, R. A. A.: Clinical Description of Disease Resembling Poliomyelitis, Seen in Adelaide, 1949-1951, M. J. Australia 1:944-946 (June 30) 1951.
8. Warin, J. F.: Davies, J. B. M.; Sanders, F. K., and Vizoso, A. D.: Oxford Epidemic of Bornholm Disease, 1951, Brit. M. J. 1:1345-1351 (June 20) 1953.
9. White, D. N., and Burtch, R. B.: Iceland Disease; New Infection Simulating Acute Anterior Poliomyelitis, Neurology 4:506-516 (July) 1954.

311 Lincoln Road.

ABSTRACTS

A Critique on the Therapeutic Value of Lumbar Sympathectomy. By Arthur R. Nelson, M.D., and I. Ridgeway Trimble, M.D. Surgery 39:797-804 (May) 1956.

This report concerns an effort to evaluate therapeutic results in 192 patients treated by lumbar sympathectomy for various disorders at The Johns Hopkins Hospital between 1946 and 1951, and followed for a minimum of two years. The great majority were followed for four and five year periods. The total group of 251 in this study was evaluated from the standpoint of operative mortality and postoperative complications. The series of 192 which was adequately followed represents 272 extremities subjected to operation, and forms the basis for the statistical appraisal of therapeutic results.

Of particular interest was the use of laboratory tests to predict the therapeutic result. It was found that predicting the result of operation for an individual patient was impossible by any clinical or laboratory procedure used for preoperative evaluation in this series, including the presence or absence of pedal pulses and the use of the skin-resistance test.

Poor results of sympathectomy were noted in 59 to 74 per cent of all patients with arteriosclerosis, arteriosclerosis complicated by diabetes mellitus, Buerger's disease, and the postphlebitic syndrome. The presence of any tissue necrosis decreased the likelihood of a good result. The operative mortality in 251 patients (364 extremities) undergoing lumbar sympathectomy was 1.2 per cent. All deaths occurred among patients with diabetes mellitus.

It is urged that in the light of these results, a more vigorous attempt be made to screen patients for possible direct attack on the offending occlusion.

Serial Electrocardiographic Changes of Myocardial Infarction Occurring in a Case of Cerebral Hemorrhage. By Maurice Rich, M.D., and Martin S. Belle, M.D. South M. J. 50:799-802 (June) 1957.

A case of cerebral hemorrhage, with serial electrocardiographic changes highly suggestive of acute myocardial infarction but without postmortem findings of myocardial infarct, is described. There is a short review of possible electrocardiographic patterns encountered in cerebrovascular accidents. Also, brief comment is made regarding the possible explanations of the electrocardiographic alterations noted in this case, as well as changes in the cardiovascular dynamics secondary to factors of the central nervous system.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

Eighty-Fourth Annual Convention

May 11-14, 1958 · Bal Harbour



Program of Eighty-Fourth Annual Convention

General Information

Registration

The Registration Desk, located in the Theatre Auditorium, Americana Hotel, will be open Sunday, Monday and Tuesday 8:30 a.m. to 5:30 p.m. and Wednesday 8:30 a.m. to 12:30 p.m. Each member is required to register and obtain identification badge before attending any sessions. Guests and ladies are also required to register. There is no fee. Printed programs are available at the Desk.

Convention Headquarters

Headquarters are the Americana Hotel where most activities are scheduled. Specialty groups, approved by the Board of Governors, will also hold their meetings concurrently.

Association Dinner

The Annual Dinner is scheduled for 7:30 p.m. Tuesday in the Bal Masque Room.
Tickets are $10.50 per person and are available at the Association's Registration Desk.

President's Reception

If weather permits, the President's Reception will be held on the Starlite Patio. In case of inclement weather, the Reception will be held in the Medallion Room. Tickets are $3.00 per person available at the Association's Registration Desk. The time is 6:30 to 8:00 p.m., Monday.

Blue Shield

The Annual Meeting of Blue Shield is being held at 4:00 p.m. Monday afternoon in the Bal Masque Room. There will be no conflicting meetings. All delegates seated at the First Session of the House of Delegates on Sunday are urged to attend. Delegates are Active Members of Blue Shield.

County Society Presidents and Secretaries

Dr. Jere W. Annis, President-Elect, has requested all component county medical society presidents and secretaries to meet with him for breakfast Tuesday morning at 8:00 in the Caribbean Room. Executive secretaries are especially invited.

Council

A meeting of the members of the Council of the Florida Medical Association has been scheduled for Tuesday, May 12, at 2:00 p.m. in Rooms 202-203, Americana Hotel.

Technical Exhibits

The Technical Exhibits will be located in the Theatre Auditorium of the Americana Hotel and may be visited Sunday, Monday and Tuesday from 8:30 to 5:30 and on Wednesday from 8:30 to 12:30 p.m. These Exhibits are an important part of the Eighty-Fourth Annual Convention, and each physician will be well repaid by spending some time inspecting them.

Anglers

Physicians desiring to arrange a fishing trip should contact the Superintendent of Services or the Bell Captain at the Americana the day before the planned trip. Rates vary from $35 to $75 a day, tackle furnished. Those interested in bone or tarpon fishing on the Keys should contact a member of the Anglers Committee: Drs. Robert F. Dickey, Chairman, John W. Dix, John R. Hilsenbeck and John T. Kilpatrick.

Florida Medical Committee for Better Government

The annual meeting and election of officers for the Florida Medical Committee for Better Government is scheduled for Sunday beginning at 8:00 p.m., Rooms 204-205, Americana Hotel.

Golf

The Golf Tournament will be held at the Westview Country Club, May 12-13. The Club is located near Opa Locka. Dr. Julian A. Rickles, of Miami, is chairman of the Golf Committee. Other members include Drs. Maxwell M. Sayet, Sanford Levine and Truxton L. Jackson. Participants in the Tournament are encouraged to bring their own equipment.

Competition will be for the Duval County Medical Society Trophy, won last year by Dr. Edson J. Andrews, of Tallahassee, and the Orlando Loving Cup, awarded to Dr. Paul J. McCloskey, of Tampa.

Members of the Woman's Auxiliary will hold their annual tournament at the same course with a separate list of prizes including the Orange County Medical Society Trophy for low gross.

Convention Committees

Anglers

Robert F. Dickey, Chairman
John W. Dix
John R. Hilsenbeck
John T. Kilpatrick

Golf

Julian A. Rickles, Chairman
Maxwell M. Sayet
Sanford Levine
Truxton L. Jackson

Meetings of Specialty Societies

Saturday and Sunday

FLORIDA ALLERGY SOCIETY

Norris M. Beasley, President Fort Lauderdale
George F. Hieber, Pres.-Elect St. Petersburg
I. Irving Weintraub, Secy.-Treas. Gainesville

Sunday, May 11

Americana — Room 210

10:00 a.m. Business Meeting

8:00 p.m. *"Treatment of Severe Allergic Reactions to Insect Stings and Bites,"* J. Warrick Thomas, Director, Thomas Clinic, Richmond, Va.

FLORIDA SOCIETY OF ANESTHESIOLOGISTS

Stanley H. Axelrod, President Miami Beach
Breckinridge W. Wing, Pres.-Elect Orlando
Richard S. Hodes, Vice Pres. Tampa
George C. Austin, Secy.-Treas. Miami

Saturday, May 10

Americana — Room 206

8:00 p.m. Executive Committee Meeting

Sunday, May 11

Americana — Westward Room

10:00 a.m. Business Meeting and Election of Officers

FLORIDA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Clarence M. Sharp, President Jacksonville
George L. Baum, Vice Pres. Coral Gables
M. Eugene Flipse, Secy.-Treas. Miami
Ivan C. Schmidt, Program Chairman West Palm Beach

Sunday, May 11

Americana — Bermuda Room

8:45 a.m. Business Meeting

9:10 a.m. *"The Association of Chronic Obstructive Pulmonary Emphysema with Chronic Peptic Ulceration,"* Louis Zasly, Delray Beach

9:35 a.m. *"A Comparison of Clinical with X-Ray and Pulmonary Function Laboratory Estimation, Timed and Total Vital Capacity,"* Milton B. Cole, Bay Pines

10:00 a.m. *"Dysphagia,"* Myron I. Segal, Hollywood

10:25 a.m. *"Clinical Significance of Solitary Pulmonary Nodules: 60 Collected Cases with Roentgenologic and Pathologic Correlations,"* Franklin G. Norris, Orlando

10:50 a.m. *"Anticoagulants in Impending Myocardial Infarction,"* E. Sterling Nichol, Miami

11:15 a.m. *"The Use of Prednisolone in Far Advanced Pulmonary Tuberculosis: Report of Four Seriously Ill Colored Females Who Had Failed to Respond to Conventional Therapy,"* Mary Lou McIlhany, Lantana

11:40 a.m. *"Management of Carcinoma of the Lung in Elderly and Poor Risk Patients,"* DeWitt C. Daughtry, Miami

12:00 Luncheon—Bermuda Room

1:00 p.m. *"Fungus Diseases of the Lungs,"* David T. Smith, Chairman of the Department of Bacteriology, Duke University School of Medicine, Durham

1:50 p.m. *"Surgical Aspects of Diaphragmatic Hernia,"* James D. Moody, Orlando

2:15 p.m. X-Ray Seminar
Those in attendance are requested to bring x-rays for discussion after presenting a brief and pertinent clinical history.

3:00 p.m. Adjournment

NOTE: Rooms have been assigned to the various specialty groups in the Americana Hotel. The Florida Medical Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

FLORIDA ACADEMY OF GENERAL PRACTICE

Henry L. Harrell, President Ocala
Charles R. Sias, Pres.-Elect Orlando
Charles D. Cooksey, Vice Pres. Jacksonville
A. MacKenzie Manson, Secy.-Treas. Jacksonville
Elmer B. Campbell Sr., Program Chair. St. Petersburg

Sunday, May 11

Americana — Rooms 202-203

10:00 a.m. Board Meeting

8:00 p.m. General Meeting and Business Session—Floridian Room
"Cancer Detection in the Office of the Generalist," John S. DeTar, Milan, Mich., Immediate Past President, American Academy of General Practice

FLORIDA SOCIETY OF DERMATOLOGY

The Florida Society of Dermatology will not hold its annual meeting at the time of the Eighty-Fourth Annual Convention of the Florida Medical Association. This specialty society is having a combined meeting with the Southeastern Dermatological Association on April 19-20 at the Balmoral Hotel, Bal Harbour.

FLORIDA HEALTH OFFICERS' SOCIETY

Paul W. Hughes, President — Fort Lauderdale
Henry I. Langston, Vice Pres. — Marianna
Lorenzo L. Parks, Secy.-Treas. — Jacksonville

Sunday, May 11

AMERICANA — CARIOCA ROOM

10:00 a.m. *"Research in Public Health in Florida,"* Albert V. Hardy, Assistant State Health Officer, Jacksonville

Discussion

10:25 a.m. *"Use and Value of a Tumor Clinic Register,"* John J. Fomon, Director, Tumor Clinic, Jackson Memorial Hospital, Miami

Discussion

10:50 a.m. *"Treatment of Tuberculosis,"* Roberts Davies, Director, State Tuberculosis Board, Tallahassee

Discussion

11:15 a.m. *"Alcoholism and Public Health,"* Mr. Ernest A. Shepherd, Administrator, State of Florida Alcoholic Rehabilitation Program, Avon Park

Discussion

11:40 a.m. *"Nutrition - Role of the Health Department in a Weight Control Program,"* Miss Ramona Powers, Regional Nutrition Consultant, Miami

Discussion

12:00 Business Session

FLORIDA ASSOCIATION OF INDUSTRIAL AND RAILWAY SURGEONS

Francis T. Holland, President — Tallahassee
William G. Harris, Pres.-Elect — Jacksonville
Gordon H. McSwain, Vice Pres. — Arcadia
John H. Mitchell, Secy.-Treas. — Jacksonville

Sunday, May 11

AMERICANA — FLORIDIAN ROOM

10:30 a.m. Panel Discussion

"Man with Trauma Versus Trauma in Man - Back and Head Injuries," Drs. John D. Ferrara, Moderator; Frank L. Fort, James G. Lyerly Sr., William H. McCullagh and G. Frederick Oetjen, Jacksonville

Business Meeting; Election of Officers

FLORIDA SOCIETY OF INTERNAL MEDICINE

Donald F. Marion, President — Miami
W. Dean Steward, Pres.-Elect — Orlando
Charles K. Donegan, Secy.-Treas. — St. Petersburg

Sunday, May 11

AMERICANA — BARBADOS ROOM

9:00 a.m. Program to be announced

The Technical Exhibits are an important part of the Eighty-Fourth Annual Convention. They are located in the Theatre Auditorium. Be sure to spend some time there as an expression of your appreciation to the firms represented.

FLORIDA OBSTETRIC AND GYNECOLOGIC SOCIETY

S. Carnes Harvard, President — Brooksville
Joseph W. Douglas, Pres.-Elect — Pensacola
T. Bert Fletcher Jr., Secy.-Treas — Tallahassee

Saturday, May 10

AMERICANA — MEDALLION ROOM

5:00 p.m. Executive Committee Meeting

6:00 p.m. Cocktail Party - Starlite Patio

7:30 p.m. Dinner - Medallion Room

"Luke's Case - Diagnosis in Retrospect," S. Buford Word, Assistant Professor of Obstetrics and Gynecology, Medical College of Alabama, Birmingham

Sunday, May 11

AMERICANA — LOWER BALL ROOM, NORTH SECTION

9:00 a.m. Business Meeting and Election of Officers

10.00 a.m. *"Pitfalls of Uterine Curettage,"* Buford Word, Assistant Professor of Obstetrics and Gynecology, Medical College of Alabama, Birmingham

FLORIDA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Carl S. McLemore, President — Orlando
Edson J. Andrews, Pres.-Elect — Tallahassee
G Dekle Taylor, 1st Vice Pres. — Jacksonville
Kenneth S. Whitmer, 2nd Vice Pres. — Miami
Joseph W. Taylor Jr., Secy.-Treas. — Tampa

Sunday, May 11

AMERICANA — MEDALLION ROOM

9:00 a.m. President's Address

Scientific Session

"Practical Points in Ophthalmic Surgery," John M. McLean, Professor of Ophthalmology, Cornell University Medical College, New York City

"Diagnosing the Child Without Speech," James W. McLaurin, Professor of Otolaryngology, Tulane University School of Medicine, New Orleans

"Localized Diathermy in Traumatic Hyphemia," Benjamin Glaser, Orlando

"Cancer of the Larynx; The Need for Early and Accurate Diagnosis and Treatments," Color Movie, Laryngofissure Operation, Orville N. Nelson, St. Petersburg

General Session

Annual Report, Florida Council for the Blind, Mr. Harry E. Simmons, Executive Director

Presentation of Past President's Key

Business Meeting; Election of Officers

6:30 - 7:30 p.m. Cocktail Party, Westward Room, Americana

FLORIDA ORTHOPEDIC SOCIETY

Robert P. Keiser, President Coral Gables
Harry W. Beller, Vice Pres. Miami
Elwin G. Neal, Secy.-Treas. Miami
Theodore Norley, Program Chairman West Palm Beach
Fred H. Albee Jr., Program Co-Chair. Daytona Beach

Saturday, May 10

Americana — Floridian Room

1:00 p.m. Business Session (Florida Orthopedic Society)

2:00 p.m. *"Slipped Capital Femoral Epiphysis,"* Wallace E. Miller, Chairman and Professor of Orthopedic Surgery, University of Miami

6:00 p.m. Cocktail Party—Carioca Terrace

Sunday, May 11

Americana — Gaucho Room

Joint Meeting with Florida Pediatric Society for those so desiring.

9:00 a.m. *"Spastic Paralysis of Early Childhood; Its Detection, Significance and Treatment,"* Temple Fay, Consultant in Neurosurgery, Philadelphia General Hospital, Philadelphia.

9:45 a.m. *"Natural Course of Brain-Injured Child,"* William Berenberg, Chief, Cerebral Palsy Unit, City Hospital, Boston; Associate Professor of Pediatrics, Harvard Medical School.

10:30 a.m. Round Table Discussion.

FLORIDA SOCIETY OF PATHOLOGISTS

Wray D. Storey, President Tampa
W. Ansell Derrick, Vice Pres. Orlando
James B. Leonard, Treasurer Clearwater
Clarence W. Ketchum, Secretary Tallahassee

Sunday, May 11

Americana — Room 310

9:00 a.m. Business Session, to be followed with Slide Seminar

FLORIDA PEDIATRIC SOCIETY

Henry G. Morton, President Sarasota
Burns A. Dobbins Jr., Pres.-Elect Fort Lauderdale
Fred I. Dormon Jr., Treasurer Lakeland
Harry M. Edwards, Secretary Ocala

Saturday, May 10

Americana — Westward Room

2:00 p.m. *"Early Recognition and Management of Brain-Injured Child,"* William Berenberg, Chief, Cerebral Palsy Unit, City Hospital, Boston; Associate Professor of Pediatrics, Harvard Medical School

3:15 p.m. *"Ancient and Modern Views on Epilepsy with Prevailing Measures for Its Treatment and Control,"* Temple Fay, Consultant in Neurosurgery, Philadelphia General Hospital, Philadelphia

5:30 p.m. Cocktail Party — Eastward Room

7:00 p.m. Banquet—Location to be announced.

Sunday, May 11

Americana — Gaucho Room

Joint Meeting with Florida Orthopedic Society

9:00 a.m. *"Spastic Paralysis of Early Childhood: Its Detection, Significance and Treatment,"* Temple Fay, Consultant in Neurosurgery, Philadelphia General Hospital, Philadelphia

9:45 a.m. *"Natural Course of Brain-Injured Child,"* William Berenberg, Chief, Cerebral Palsy Unit, City Hospital, Boston; Associate Professor of Pediatrics, Harvard Medical School

10:30 a.m. Round Table Discussion

12:00 Business Session (Florida Pediatric Society)

FLORIDA SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY

George W. Robertson III, President Miami
Grover W. Austin, Vice Pres. St. Petersburg
Bernard L. N. Morgan, Secy.-Treas. Jacksonville

Sunday, May 11

Americana — Room 206

10:00 a.m. Annual Business Meeting; Election of Officers

FLORIDA PROCTOLOGIC SOCIETY

George Williams Jr., President Miami
Thomas F. Nelson, Vice Pres. Tampa
Sam N. Sulman, Secy.-Treas. Orlando

Saturday, May 10

Americana — Barbados Room

12:00 Luncheon — To be announced

1:00 p.m. Business Meeting
Discussion of Blue Shield and Report of Committee of Seventeen, John J. Cheleden, Daytona Beach
Election of Officers

3:00 p.m. Scientific Meeting

Round Table Discussions:

"Newer Drugs Related to Proctology, such as Adrenosem Salicylate, Cortisone Derivatives and Muscle Relaxants"

"Newer Drugs Related to Pruritis Ani and Coccygodynia"

7:00 p.m. Cocktail Party — To be announced

8:00 p.m. Dinner — To be announced

FLORIDA PSYCHIATRIC SOCIETY

William H. Everts, President West Palm Beach
James L. Anderson, Pres.-Elect Miami
Samuel G. Hibbs, Secretary Tampa

Saturday, May 10

AMERICANA — BERMUDA ROOM

10:00 a.m. *"Emotional Stress and Epinephrine—Norepinephrine Metabolism,"* Peter F. Ragan III, Chairman, Department of Psychiatry, College of Medicine, University of Florida, Gainesville

"Neurology and Psychiatry in Private Practice," William M. C. Wilhoit, Pensacola

"Programs in Psychiatry, School of Medicine," John M. Caldwell, Chairman, Department of Psychiatry, School of Medicine, University of Miami, Coral Gables

Sunday, May 11

AMERICANA — ROOMS 204-205

10:00 a.m. *"Neurologic Diagnosis in Psychiatric Patients,"* Theodore J. C. Von Storch, Miami

"Report of Activities of the Committee of Mental Health Training and Research," John T. Benbow, Clinical Director, Florida State Hospital, Chattahoochee

"Treatment Programs at the South Florida State Hospital," Arnold H. Eichert, Director, South Florida State Hospital, Hollywood

Business Meeting; Election of Officers

FLORIDA RADIOLOGICAL SOCIETY

Donald H. Gahagen, President Fort Lauderdale
C. Robert DeArmas, Vice Pres. Daytona Beach
Russell D. D. Hoover, Secy.-Treas. West Palm Beach

Saturday, May 10

AMERICANA — EASTWARD ROOM

1:30 p.m. Film Session

Sunday, May 11

AMERICANA — EASTWARD ROOM

9:00 a.m. Business Meeting

FLORIDA UROLOGICAL SOCIETY

W. Dotson Wells, President Fort Lauderdale
Melvin M. Simmons, Pres.-Elect Sarasota
Edwin W. Brown, Secy.-Treas. West Palm Beach

Sunday, May 11

AMERICANA — LOWER BALL ROOM, SOUTH SECTION

10:00 a.m. Program to be announced

FLORIDA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Julius C. Davis, President Quincy
Morris H. Blau, Vice Pres. Miami
C. Frank Chunn, Secy.-Treas. Tampa
Walter C. Jones, Program Chairman Miami

Sunday, May 11

AMERICANA — BAL MASQUE ROOM

10:00 a.m. Scientific Session

"Fallacies of Tetanus Prophylaxis," Norman M. Kenyon, Resident Surgeon, Jackson Memorial Hospital, Miami

"Carcinoma of the Colon," Dr. Samuel F. Marshall, Lahey Clinic, Boston, Mass.

BLUE SHIELD OF FLORIDA

Russell B. Carson, President Fort Lauderdale
George S. Palmer, Vice Pres. Tallahassee
Hunter B. Rogers, Vice Pres. Miami
John T. Stage, Secretary Jacksonville
Mr. H. A. Schroder, Asst. Secretary Jacksonville
Floyd K. Hurt, Treasurer Jacksonville
Samuel M. Day, Asst. Treasurer Jacksonville

Saturday, May 10

AMERICANA — ROOMS 202-203

2:30 p.m. Board of Directors Meeting

FLORIDA MEDICAL COMMITTEE FOR BETTER GOVERNMENT

AMERICANA — ROOMS 204-205

8:00 p.m. Annual Meeting; Election of Officers

Charles F. Henley, State Chairman, Jacksonville
O. E. Harrell, Secy.-Treas., Jacksonville

FLORIDA CANCER COUNCIL

Ashbel C. Williams, Chairman Jacksonville
Lorenzo L. Parks, Secretary Jacksonville
Millard B. White Sarasota
Turner E. Cato Miami
Samuel B. D. Rhea Pensacola
Joseph J. Zavertnik Miami
Courtlandt D. Berry Orlando

Sunday, May 11

AMERICANA — ROOM 206

8:30 p.m. Business Meeting

STATE BOARD OF HEALTH

Sunday, May 11

AMERICANA — ROOM 207

9:00 a.m. Meeting

First Meeting House of Delegates

Sunday, 2:30 p.m.

Bal Masque Room

Delegates assemble at the Credentials Committee table at the entrance to the Bal Masque Room at 2:30 p.m. to present their credentials, fill out attendance cards and receive special badges from the Credentials Committee:

Louis M. Orr, *Chairman*
Ralph W. Jack
Herbert L. Bryans

Delegates are to occupy seats in the designated section. Other members of the Association and guests are requested to occupy seats in the other sections of the room.

3:00 p.m., President Roberts in the Chair

Invocation: Homer L. Pearson Jr.

Parliamentarian for the President—George F. Schmitt Jr.

Number of eligible Delegates present, report by Louis M. Orr

Motion to seat Delegates if quorum is present

Approval of minutes of 1957 Annual Meeting as published in July, 1957 Journal

Approval of minutes of called meeting Dec. 8, 1957 as published in February, 1958 Journal

Gavel to First Vice President, Ralph W. Jack

President's Address, William C. Roberts

President Resumes Chair

Recognition: John S. DeTar, Immediate Past President, American Academy of General Practice

Recognition: Woman's Auxiliary and other guests

Report: Homer L. Pearson Jr., Secretary, State Board of Medical Examiners

Report on Medicare: John D. Milton

Report: Representative to Student A.M.A. Convention

Election of two Delegates and two Alternates to A.M.A. House of Delegates for two year terms beginning Jan. 1, 1959

(Terms expiring Dec. 31, 1958: Delegate Reuben B. Chrisman; Alternate Frank D. Gray; Delegate Francis T. Holland; Alternate Walter E. Murphree) (A.M.A. By-Laws, Chapter IX, Sec. 1: "In order to be eligible for election to membership in the House of Delegates, a physician must have been an Active or Service Member of the American Medical Association for at least two years immediately preceding the session of the House in which he is to serve")

Reference Committee Personnel announced by President Roberts

1. HEALTH AND EDUCATION
 Floridian Foyer
 C. Frank Chunn, *Chairman*
 Walter E. Murphree
 Walter J. Glenn Jr.
 Kenneth A. Morris
 Paul F. Baranco

2. PUBLIC POLICY
 Eastward Room
 Robert F. Dickey, *Chairman*
 Leo M. Wachtel
 Robert L. Tolle
 Norval M. Marr Sr.
 Marion W. Hester

3. FINANCE AND ADMINISTRATION
 Barbados Room
 Herbert E. White, *Chairman*
 Edward W. Cullipher
 Egbert V. Anderson
 H. Phillip Hampton
 Donald F. Marion

4. LEGISLATION AND MISCELLANEOUS
 Bermuda Room
 L. Washington Dowlen, *Chairman*
 Burns A. Dobbins Jr.
 Joseph J. Lowenthal
 Millard P. Quillian
 Edward R. Annis

5. BLUE SHIELD
 Westward Room
 Thomas C. Kenaston, *Chairman*
 S. Carnes Harvard
 Ernest R. Bourkard
 W. Dean Steward
 Wm. F. Humphreys Jr.

Presentation of Resolutions and Supplemental Reports (Resolutions not included in House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.)

Reports of Committee Chairmen and Resolutions:

(To Reference Committee No. 1)

Scientific Work, George T. Harrell Jr.
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Ashbel C. Williams
Venereal Disease Control, C. W. Shackelford
Tuberculosis and Public Health, Lorenzo L. Parks
Maternal Welfare, E. Frank McCall
Child Health, Warren W. Quillian
Report of Secretary, State Board of Medical Examiners, Homer L. Pearson Jr.
Report: Representative to Student A.M.A. Convention

(To Reference Committee No. 2)

Conservation of Vision, Carl S. McLemore
Medical Education and Hospitals, Jack Q. Cleveland
Medical Economics, Robert E. Zellner
Representatives to Industrial Council, Pascal G. Batson Jr.
Grievance, Frederick K. Herpel
Nursing, Thomas C. Kenaston
Blood, James N. Patterson

(To Reference Committee No. 3)

Address of President, William C. Roberts
Board of Governors, William C. Roberts
Necrology, J. Basil Hall
Advisory to Woman's Auxiliary, Merritt R. Clements
Councilor Districts and Council, S. Carnes Harvard
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Civil Defense and Disaster, J. Rocher Chappell
Resolution: Discontinuance of District Meetings
Report on Medicare, John D. Milton

(To Reference Committee No. 4)

Legislation and Public Policy, H. Phillip Hampton
Mental Health, Sullivan G. Bedell
State Controlled Medical Institutions, William D. Rogers
Poliomyelitis Medical Advisory, Richard G. Skinner Jr.

Resolution: BB Guns To Be Declared Illegal
Resolution: Forand Bill

(To Reference Committee No. 5)

Advisory to Blue Shield, Henry J. Babers Jr.
Resolution: Blue Shield Board of Directors
Other Business
Announcements
Adjournment

General Session

Monday, May 12

BAL MASQUE ROOM

9:30 a.m. Call to Order, William C. Roberts, President

Invocation

Address of Welcome, Nelson Zivitz, Miami Beach, President, Dade County Medical Association

Introduction, Fraternal Delegates and other eminent guests

Announcements

9:55 a.m. *"Civil Defense, Past, Present and Future,"* J. Rocher Chappell, Orlando, Chairman, Committee on Civil Defense and Disaster, Florida Medical Association

10:10 a.m. *"Is the Game Worth the Candle?"* David B. Allman, Atlantic City, President, American Medical Association

10:40 a.m. *"The Greatest Problem of Medical Education and Its Relation to Medical Practice,"* O. W. Hyman, Dean, University of Tennessee College of Medicine, Memphis; Vice President in Charge of Medical Units (Guest of President Roberts)

11:00 a.m. Recess to visit the Technical and Scientific Exhibits

General Scientific Addresses

11:30 a.m. *"Organ Transplantation—Past, Present and Future,"* David M. Hume, Richmond, Va., Chairman of the Department of Surgery, Medical College of Virginia

12:00 noon *"The Role of the General Physician in the Changing Picture of Tuberculosis,"* David T. Smith, Durham, N. C., Chairman of the Department of Bacteriology, Duke University School of Medicine

Adjournment

LUNCHEONS

12:30 to 2:00 p.m.

Alumni, Fraternity, Specialty Groups

THETA KAPPA PSI

AMERICANA — DOMINION COFFEE HOUSE

12:30 p.m. Luncheon
All attending must register with young lady at marked table in the lobby

REFERENCE COMMITTEES

2:00 to 4:00 p.m.

No. 1 Health and Education — Floridian Foyer
No. 2 Public Policy — Eastward Room
No. 3 Finance and Administration — Barbados Room
No. 4 Legislation and Miscellaneous — Bermuda Room
No. 5 Blue Shield — Westward Room

BLUE SHIELD

AMERICANA — BAL MASQUE ROOM

4:00 p.m. Annual Meeting; Election of Officers

PRESIDENT'S RECEPTION

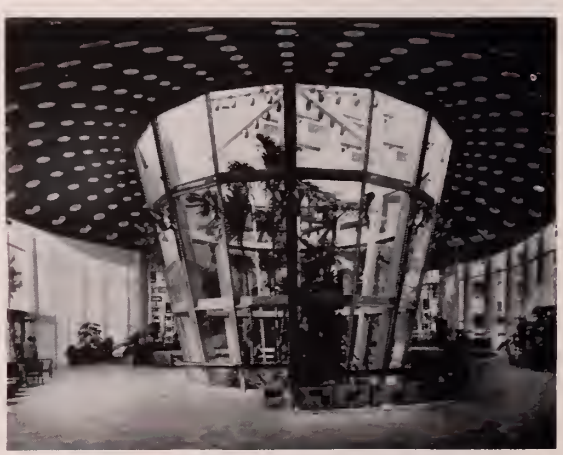
AMERICANA — STARLITE PATIO

6:30-8:00 p.m. No formal program. Tickets $3.00 per person, available at Association's registration desk during registration hours or entrance to Patio prior to Reception. If weather is inclement, Reception will be held in Medallion Room

FLORIDA TULANE MEDICAL ALUMNI

AMERICANA — BERMUDA ROOM

6:00 p.m. Cocktail Party followed by dinner



Dominating the circular lobby of the Americana Hotel is a huge terrarium containing a miniature volcano-type mountain and one of the most complete collections of subtropical rain forest flora in existence.

Scientific Assemblies

Tuesday, May 13

Bal Masque Room

Committee on Scientific Work: George T. Harrell Jr., Chairman, Gainesville; Franz H. Stewart, Miami; Donald F. Marion, Miami; Richard Reeser Jr., St. Petersburg, and Gretchen V. Squires, Pensacola.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the Secretary when read.

"No address or paper before the Association, except those of the president and orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any subject."

FIRST SESSION

Presiding: George T. Harrell Jr.

9:30 a.m. *"Hearing Loss in Persons of Advanced Age"*
Abraham R. Hollender and Otto S. Blum, Miami Beach. Presented by Dr. Hollender.
Discussion: G. Dekle Taylor, Jacksonville

9:55 a.m. *"An Analysis of the Causes of Blindness in Florida"*
Nathan S. Rubin, Pensacola
Discussion: William Y. Sayad, W. Palm Beach
John F. McKenna, South Miami

10:20 a.m. *"False Positive Pregnancy Tests Caused by Sparine and Thorazine"*
Gerard H. Hilbert, Pensacola
Discussion: Daniel O. Hammond, Miami

10:45 a.m. Recess to visit exhibits

Presiding: Richard Reeser Jr.

11:00 a.m. Panel: Recent Advances in Modern Methods of Diagnosis and Therapy
Moderator: David M. Hume, Chairman of the Department of Surgery, Medical College of Virginia, Richmond
"Reversal of Intractable Cardiac Edema"
David A. Newman, Palm Beach
"The Use of Carbon Dioxide in the Treatment of Postconcussion Syndromes"
Michael M. Gilbert, Miami
"The Value of Bone Marrow Examination in the Diagnosis of Malignant Disease"
Robert G. Cushman, Jacksonville

SECOND SESSION

Presiding: Donald F. Marion

2:00 p.m. *"Physiologic Basis for Ulcer Surgery"*
Edward R. Woodward, Gainesville
Discussion: Robert F. Dickey, Miami
John J. Farrell, Miami

2:25 p.m. *"Ventricular Aneurysm"*
Richard G. Connar, Tampa
Discussion: Samuel P. Martin, Gainesville
Robert S. Litwak, Miami

2:50 p.m. Recess to visit exhibits

Presiding: Franz H. Stewart

3:00 p.m. Panel: Medical and Surgical Aspects of Chest Diseases
Moderator: David T. Smith, Chairman of the Department of Bacteriology, Duke University School of Medicine, Durham
"Differential Diagnoses of Pulmonary Tuberculosis"
George H. Hames, Lantana
"Office and Bedside Evaluation of Pulmonary Function"
William W. Stead, Gainesville
"Surgery in the Relief of Dyspnea of Ventilatory Origin"
John G. Chesney, DeWitt C. Daughtry and Harold C. Spear, Miami. Presented by Dr. Chesney.
"Pulmonary Surgery in Infants and Children"
Hawley H. Seiler, Tampa

CONFERENCE OF COUNTY MEDICAL SOCIETY PRESIDENTS AND SECRETARIES

Americana — Caribbean Room

8:00 a.m. Breakfast
Jere W. Annis, President-Elect, Florida Medical Association, presiding.

ASSOCIATION DINNER

Americana — Bal Masque Room

7:30 p.m. No formal program. Tickets $10.50 per person available at Association's registration desk.



The tropical garden of the Americana Hotel has tended areas in abstract geometric patterns, separated by reefs of native Florida coral.

Second Meeting House of Delegates

Wednesday, 9:00 a.m.

BAL MASQUE ROOM

Delegates sign official attendance cards at 9:00 a.m. at the table of the Credentials Committee, Louis M. Orr, Chairman, Ralph W. Jack and Herbert L. Bryans, located at entrance to the Bal Masque Room. No alternates are to be seated for Delegates attending Sunday's meeting.

9:30 a.m., President Roberts in the Chair

Number of eligible Delegates present, report by Louis M. Orr

Recognition: President, Florida Bar, Baya M. Harrison Jr.

Presentation of Life Certificates

Recommendations of Reference Committees:

- No. 1 Health and Education
 C. Frank Chunn, Chairman
- No. 2 Public Policy
 Robert F. Dickey, Chairman
- No. 3 Finance and Administration
 Herbert E. White, Chairman
- No. 4 Legislation and Miscellaneous
 L. Washington Dowlen, Chairman
- No. 5 Blue Shield
 Thomas C. Kenaston, Chairman

Other unfinished business

Election of Association Officers, 12:00 noon
- President-Elect
- First Vice President
- Second Vice President
- Third Vice President
- Secretary-Treasurer
- Editor of The Journal

Dr. Jere W. Annis escorted to the Chair as new President

Presentation of Personal Gavel to Dr. Annis

Presentation of Past President's Button and Certificate of Honor to Dr. William C. Roberts by Dr. Jere W. Annis, President

Benediction: Homer L. Pearson Jr.

Adjournment

BOARD OF PAST PRESIDENTS

AMERICANA — GAUCHO ROOM

8:00 a.m. Breakfast

Election of a Chairman and Secretary
Leigh F. Robinson, Chairman, and Francis H. Langley, Secretary
(According to precedence, Walter C. Jones will succeed the present chairman and William C. Roberts the present secretary.)



The Bal Masque Room of the Americana Hotel will be the location for the principal activities of the Eighty-Fourth Annual Convention.

Technical Exhibits

Technical exhibits will be located in the Theatre Auditorium of the Americana Hotel. They have a real scientific value, and physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way.

Many exhibitors make no attempt to sell, the representatives of the firms being there primarily to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting. The following firms have arranged for exhibits at the Bal Harbour meeting:

Exhibitors	Booth
Abbott Laboratories	85
A. S. Aloe Company	81
American Ferment Co., Inc.	98
Anderson Surgical Supply Co.	112
Arlington-Funk Laboratories	134
Atlas Pharmaceutical Labs., Inc.	89
Audio-Digest Foundation	66
Ayerst Laboratories	78
Baxter Laboratories, Inc.	104
The Borden Company	60
Brayten Pharmaceutical Co.	118
Burroughs Wellcome & Co.	124
S. H. Camp & Co.	75
Chicago Pharmacal Co.	52
Ciba Pharmaceutical Products, Inc.	63
The Coca-Cola Co.	140
Continental X-Ray Corp. & Standard X-Ray Co.	108
Coreco Research Corp.	76
Desitin Chemical Co.	51
Dictaphone Corp.	10
Doho Chemical Corp.	74
Dome Chemicals, Inc.	11
Drug Specialties, Inc.	12
Eaton Laboratories	101
Eisele and Co.	128
Encyclopaedia Brittannica, Inc.	92
Encyclopedia Americana	59
Enfield's	14
Executone, Inc.	9
C. B. Fleet Co., Inc.	138
Florida Brace Corp.	79
Geigy Pharmaceuticals	126
Guild of Prescription Opticians of Fla.	8
Hart Drug Corp.	91
Hartsfield-Barnett Co.	57
Charles C. Haskell & Co., Inc.	133
Hoffmann-LaRoche, Inc.	96
Holland-Rantos Co., Inc.	83
Keisacker	50
Keleket X-Ray of Florida	130
Knoll Pharmaceutical Co.	113
Kremers-Urban Co.	127
Lederle Laboratories	71
Eli Lilly & Co.	82
J. B. Lippincott Co.	109
Lloyd Brothers, Inc.	115
Loma Linda Food Co.	73
J. A. Majors Co.	111
Maltbie Laboratories	61
S. E. Massengill Co.	55
Mead Johnson & Co.	46
Medical Protective Co.	117
Medical Supply Co. of Jacksonville	136
Medical Supply Co.	139
Merck, Sharp & Dohme, Inc.	62
The Wm. S. Merrell Co.	65
C. V. Mosby Co.	100
The National Drug Co.	119
Nordmark Pharmaceutical Laboratories, Inc.	102
Organon, Inc.	67
Ortho Pharmaceutical Corp.	15
Parco Surgical Supplies	135
Parke-Davis & Co.	97
Pepsi Cola Co.	90
Pet Milk Co.	110
Pfizer Laboratories	99
Pitman-Moore Co.	86
Wm. P. Poythress & Co., Inc.	48
The Purdue Frederick Co.	53
R. J. Reynolds Tobacco Co.	16
Richards Manufacturing Co.	72
Riker Laboratories	106
Ritter Co., Inc.	120-121
A. H. Robins Co., Inc.	129
Ross Laboratories	123
Sanborn Company	87
Sandoz Pharmaceuticals	84
Schering Corp.	47
Julius Schmid, Inc.	56
Joseph E. Seagram & Sons, Inc.	107
G. D. Searle & Co.	132
Smith, Kline & French Laboratories	95
E. R. Squibb & Sons	137
The Stuart Co.	13
Surgical Equipment Co.	70
Surgical Equipment Co. of Tampa	69
Surgical Supply Co.	131
Tablerock Laboratories	122
The Upjohn Co.	64
VanPelt & Brown, Inc.	54
Walker Laboratories	80
Warner-Chilcott Laboratories	77
Westwood Pharmaceuticals	105
White Laboratories, Inc.	49
Winthrop Laboratories	125
Zenith Radio Corp.	103

Scientific Exhibits

Americana — Theatre Auditorium

1. Middle Ear and Mastoid Complications Despite the Antibiotics, G. Dekle Taylor, M.D.
2. Transplant of Digital Nerve Combined with Tailor's Bunionectomy, Edward L. Farrar Jr., M.D.
3. Hypothermia in the Correction of Intracranial Vascular Abnormalities, J. Gerard Converse, M.D., Albert J. Ehlert, M.D. and David Reynolds, M.D.
4. Intestinal Recirculation as an Aid to Absorption, H. Clinton Davis, M.D., M. W. Wolcott, M.D., and D. Golder, M.D.
5. Treatment of Facial Injuries, Thomas J. Zaydon, M.D.
6. Diagnostic Research in Cancer Cytology, J. Ernest Ayre, M.D.
7. The Migrant Worker, George W. Karelas, M.D.

7A. Dade County Medical Association, Nelson Zivitz, M.D., President

17. Florida Medical Foundation, Edward Jelks, M.D.

18-19. Food Flim-Flams, Mr. George B. Larson, American Medical Association

20. Blue Shield, Russell B. Carson, M.D.
21. The Dependents' Medical Care Program, Major Ralph O. Anderson, Office of Dependents' Medical Care

22. Recruitment Future Nurse Clubs, Allied Health Fields, Woman's Auxiliary, Mrs. Frederick B. Zaugg

23-24. Non-penetrating Injuries of the Heart and Aorta, Brig. Gen. Thomas W. Mattingly and Walter Reed Army Hospital

25-26. Auto Crash Injury Research, Sgt. E. C. Paul, Indiana State Police

27. Rheumatic Heart Disease Prophylaxis, Simon D. Doff, M.D., Florida State Board of Health

28. Low Sodium Diets, Florida Dietetic Association, Mrs. Rebecca Norfleet, and Florida Heart Association, Mr. Tom Phillips

29. The Manifestations of Muscular Dystrophy, Melville H. Manson, M.D., Muscular Dystrophy Association
30. Cancer of the Cervix, Mr. L. H. Peterson, Florida Division, American Cancer Society
31. Sunland Training Center, Charles H. Carter, M.D.
32. Accident Prevention in Hospitals, Florida Hospital Association and Florida State Board of Health
33. Case Demonstrations — Pathological Bone Lesions, Wallace E. Miller, M.D., Department of Surgery, University of Miami
34. General Practice Section in a Department of Medicine, Ralph Jones, M.D., Department of Medicine, University of Miami
35. Mass in Neck (Clinical Significance), John J. Fomon, M.D., and Victor Dembrow, M.D., Department of Surgery, University of Miami

36-37. Arthritis and Rheumatism, David S. Howell, M.D.

37A. Physical Examination and Screening Laboratory Tests for Physicians, Lorenzo L. Parks, M.D., Florida State Board of Health

37B. Phosphate Ester Insecticide Poisoning, D. O. Hamblin, M.D., and H. H. Golz, M.D.

38. Bureau of Professional Relations, College of Pharmacy, University of Florida, Mr. Charles S. Haupt
39. Nursing Education, Dorothy M. Smith, R.N., College of Nursing, University of Florida
40. The J. Hillis Miller Health Center, Russell S. Poor, Ph.D., University of Florida

40A. Florida Medical Association Insurance Plan, Mr. Leyton B. Hunter, Marsh & McLennan

41. Automation in Cytology Screening, Nelson A. Murray, M.D.
42. Trichomonas Vaginalis Infections — Relation to Abnormal Cytology, Carl H. Davis, M.D. and C. G. Grand, M.D.
43. The Use of Radioactive B-12 in Clinical Diagnosis, Raymond E. Parks, M.D.
44. Otoplasty, Richard T. Farrior, M.D.
45. Skin Cancer About the Face and Eyelids, Wesley W. Wilson, M. D.

Program

Thirty-First Annual Meeting Woman's Auxiliary to the Florida Medical Association

May 11-13, 1958

Hostess Auxiliary: Woman's Auxiliary to the Dade County Medical Association

Chairman — Mrs. Robert F. Dickey
Co-chairman — Mrs. William P. Smith

GENERAL INFORMATION

GENERAL REGISTRATION will be held along with registration of members of the Florida Medical Association at the Americana Hotel, Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., Wednesday, 8:30 a.m. to Noon.

REGISTRATION FOR DELEGATES TO AUXILIARY House of Delegates
8:30 a.m. to 9:30 a.m., Monday, May 12 (Location to be announced)

All activities are to be held at the Americana Hotel, Bal Harbour

AUXILIARY MEETINGS

SUNDAY, MAY 11

1:00 p.m. Pre-Convention Board of Directors Meeting, Floridian Foyer

3:00 p.m. First session of Florida Medical Association House of Delegates

MONDAY, MAY 12, Caribbean Room

9:30 a.m. Annual Meeting of House of Delegates, Woman's Auxiliary to the Florida Medical Association. All Auxiliary members invited to attend.

1:00 p.m. Annual Auxiliary Luncheon

6:30 p.m. President's Reception, Florida Medical Association

TUESDAY, MAY 13, Floridian Foyer

9:30 a.m. Post-Convention Board of Directors Meeting



Mrs. Perry D. Melvin
President, Woman's Auxiliary



Mrs. Lee Rogers Jr.
President-Elect, Woman's Auxiliary

10:30 a.m. School of Instruction (Open to all Auxiliary Board members, District Chairmen, County Officers and Chairmen

7:30 p.m. Annual Dinner, Florida Medical Association, dress optional

Technical Exhibit

A feature that adds materially to the success of the annual convention is the technical exhibits. Each firm represented features products of particular interest to the physician. Make a special effort to visit each booth at some time during the convention and register your name with the attending representative.

The Technical Exhibit Hall will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and on Wednesday from 8:30 a.m. to 12:30 p.m. The booths may be dismantled after 12:30 p.m.

GUILD OF PRESCRIPTION OPTICIANS OF FLORIDA — 8
EXECUTONE, INC. — 9
DICTAPHONE CORP. — 10

DOME CHEMICALS, INC. — 11

Dome Chemicals, Inc. is proud to present its ACID MANTLE group of products, including the new COR-TAR-QUIN CREME for stubborn and infectious dermatoses; HIST-A-CORT-E CREME for senile vaginitis, pruritus vulvae and kraurosis vulvae; CORT-DOME and NEO-CORT-DOME CREME and LOTION for inflammatory and infectious dermatoses, including otitis externa; the most extensive line of wet dressings, including SOYALOID COLLOID BATH; the new principle of vitamin utilization by buccal absorption in VI-DOM-A BUCCAL TABLETS and VI-DOM-A-C ORAL-TABS; and the new, safer prednisolone K-PREDNE-DOME.



The pool and an exterior view of the Americana Hotel.

DRUG SPECIALTIES, INC. — 12

NICOZOL—A cerebral stimulant and tonic for the aged, indicated in senile psychoses, cerebral arteriosclerosis with mild memory defects, abnormal behavioral patterns, and presenility.

NICOZOL WITH RESERPINE—An analeptic tranquilizer for senile psychoses with agitation.

THE STUART CO. — 13

ENFIELD'S — 14

ORTHO PHARMACEUTICAL CORP. — 15

ORTHO cordially invites you to booth #15. Featured will be DELFEN Vaginal Cream, ORTHO's most spermicidal contraceptive. Also on display will be RARICAL Iron-Calcium Tablets, a compound for use in iron-deficiency anemias and in all cases requiring calcium supplementation. ORTHO representatives welcome this opportunity to meet you and discuss their products with you.

R. J. REYNOLDS TOBACCO CO. — 16

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, WINSTON Filter, Menthol Fresh SALEM, or CAVALIER King Size Cigarettes.

MEAD JOHNSON & CO. — 46

SCHERING CORP. — 47

The Schering exhibit will feature TRILAFON, extremely potent tranquilizer and antiemetic, capable of alleviating manifestations of emotional stress without apparent dulling of mental acuity.

Extraordinary potency in behavioral effects without corresponding increase in autonomic hematologic or hepatic side effects provides a favorable therapeutic ratio and excellent versatility in clinical use.

WM. P. POYTHRESS & CO., INC. — 48

A cordial welcome awaits you at the Poythress booth. Solfoton and its companion products, Antrocol and Solfoserpine, will be featured. Also featured will be Mudrane, outstanding Poythress antiasthmatic drug; Trocinate, Poythress distinctive antispasmodic; Panalgesic, leading ethical local analgesic and counterirritant; and other well-known Poythress specialty products. Literature will be available, and your request for trial supplies of any of these drugs is invited.

WHITE LABORATORIES, INC. — 49

KEISACKER — 50

Sculpture and Illustrations by a qualified Medical Artist, who completed studies in Anatomy at University of Miami Medical School and has done outstanding work in the field. This exhibit will bring to your attention the services of an artist in our own area dedicated to serving mankind through the doctor.

DESITIN CHEMICAL CO. — 51

DESITIN OINTMENT, the pioneer cod liver oil ointment for treatment of burns, ulcers, wounds, diaper rash. DESITIN POWDER, cod liver oil dusting powder for treatment of intertrigo, diaper rash, exanthema, abrasions, etc. DESITIN HEMORRHOIDAL SUPPOSITORIES, relieve pain and itching, promote healing, give comfort in uncomplicated hemorrhoids, fissures. Contain no anesthetics or styptics. RECTAL DESITIN OINTMENT, for effective relief in simple hemorrhoids, pruritus and fissures. DESITIN LOTION, soothing protective, mildly astringent for treatment of pruritus, poison ivy and nonspecific dermatitis. DESITIN COSMETIC & NURSERY SOAP, supermild, nonallergenic, pleasantly scented, deodorant.

CHICAGO PHARMACAL CO. — 52

Chimedic featured items are URISED, nationally known and clinically proven tablet for thorough antisepsis plus comfortable sedation in all types of genitourinary affections. MERLENATE, the dual action antifungus infection formula in ointment, powder and liquid form; LIPOMIC Injection for a modern effective treatment of atherosclerosis; plus a complete line of tablets, ointments, liquids and injectables awaiting your inspection.

THE PURDUE FREDERICK CO. — 53

We cordially invite you to visit our booth where you will find our Special Representative on hand to answer your questions and offer you latest information and samples of our featured specialty pharmaceuticals:

Glutazyme Capsules and Powder—a nutritive supplement for the patient over 40.

Senokot Tablets and Granules—time proven constipation correctives, with their allied products, *Senokap*, *Senobile* and *Senokot with Psyllium*.

Pre-mens (plain and with d-Amphetamine) for multidimensional therapy of premenstrual tension.

Somatovite Liquid and Tablets—for promoting weight gain and appetite in the undernourished, underweight, hyperexcitable child.

Sippyplex—for comprehensive, peptic ulcer management.

VANPELT & BROWN, INC. — 54

VanPelt and Brown extend a cordial invitation to visit their exhibit where representatives will be happy to answer questions and supply clinical samples of their products.

S. E. MASSENGILL CO. — 55

Best wishes to the members of the Florida Medical Association for a successful and enjoyable convention. Should you desire, Massengill Representatives will be honored to discuss any Massengill Speciality Products with you. Featured are Adrenosem (the unique systemic hemostat); Obedrin (effective aid in weight control and fatigue states); Homagenets (the only homogenized vitamins in solid form); The Salcort Family (offering a complete range of therapy for arthritic disorders); Saferon (the peptonized iron).

JULIUS SCHMID, INC. — 56

An interesting and informative exhibit featuring RAMSES Flexible Cushioned Diaphragm; RAMSES Vaginal Jelly; VAGISEC Jelly and Liquid, two new products embodying "Carlendacide," the recent development of Carl Henry Davis, M.D., and C. G. Grand for vaginal trichomoniasis therapy; and XXXX (FOUREX) Skin Condoms, RAMSES and SHEIK Rubber Condoms for the control of trichomonal re-infection.

HARTSFIELD-BARNETT CO. — 57

UNASSIGNED — 58

ENCYCLOPEDIA AMERICANA — 59

THE BORDEN CO. — 60

MALTBIE LABORATORIES — 61

The Maltbie Laboratories booth features Desenex® Night and Day treatment of athlete's foot, Bifran® for control of obesity and biliary disturbance, Cholan V for effective hydrocholeresis with superior spasmolysis, Malcotran®, the effective anticholinergic with wide therapeutic range, Nesacaine®, the first local anesthetic more potent yet less toxic than procaine, and Caldesene® Medicated Powder for diaper rash.

MERCK, SHARP & DOHME, INC. — 62

A new and very promising diuretic is featured at the Merck Sharp & Dohme booth. Since the principal action of 'DIURIL' is a marked enhancement of the excretion of sodium, chloride and water, it has been designated a salureticagent. This new compound achieves a profound electrolyte and water diuresis without attendant toxic effects and other disadvantages peculiar to the mercurials and certain other diuretic agents.

Technically trained personnel will be present to discuss this and other subjects of clinical interest.

CIBA PHARMACEUTICAL PRODUCTS, INC. — 63

THE UPJOHN CO. — 64

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

THE WM. S. MERRELL CO. — 65

Bendectin, a new and exceptionally effective antinauseant for treatment and prevention of vomiting in pregnancy will be featured.

You are invited to discuss this and other Merrell research products with our representatives.

AUDIO-DIGEST FOUNDATION — 66

Audio-Digest Foundation—a subsidiary of the California Medical Association—gives the busy physician an effortless tour through the best of current medical literature each week. This medical tape-recorded "newscast" —compiled and reviewed by a professional Board of Editors—may be heard in the physician's automobile, home or office. The Foundation also offers medical lectures by nationally-recognized authorities.

ORGANON, INC. — 67

Physicians are cordially invited to visit the Organon booth for information on new therapeutic specialties. Among these will be LIQUAMAR, the new and highly potent oral anticoagulant; CORTROPHIN-ZINC, the long-acting, aqueous ACTH; ADRESTAT, the complete systemic hemostat; WIGRAINE, the rapid-acting and complete migraine treatment; and NUGESTORAL, the aid for the abortion-prone patient. Organon representatives will be happy to discuss these advances in therapy with all interested physicians.

UNASSIGNED — 68

SURGICAL EQUIPMENT CO. — 69, 70

We invite you to visit our booth where our representatives will be in attendance to show you the latest medical and surgical items.

LEDERLE LABORATORIES — 71

RICHARDS MANUFACTURING CO. — 72

An interesting and informative display of the finest in orthopedic equipment, featuring the new Campbell Boyd Pneumatic Tourniquet, the Boyce Parker Table for hand surgery, and many other invaluable time and work savers for the General Practitioner as well as the General and Orthopedic Surgeon.

LOMA LINDA FOOD CO. — 73

With the background of years of experience in perfecting a hypoallergenic milk powder, and also a newly developed concentrated liquid milk the protein of which is fully derived from the soybean and formulated with other essential additives to care for the needs of babies, growing children, and adults, the Loma Linda Food Company will be happy to welcome you to their exhibit. Attendants will be pleased to discuss the values of Soyalac powder and concentrated liquid. Samples of this flavorful product will be served at the exhibit.

THE DOHO CHEMICAL CORP. — 74

Doho Chemical Corporation is pleased to exhibit: AURALGAN, ear medication in Otitis Media and removal of cerumen. OTOSMOSAN, effective nontoxic fungicidal and bactericidal in suppurative and aural dermatomycotic ears. RHINALGAN, nasal decongestant free from systemic or circulatory effect and safe to use on infants. NEW LARYLGAN, soothing throat spray and gargle for infectious and noninfectious sore throat.

S. H. CAMP AND CO. — 75

There are many new and interesting developments in CAMP Appliances and Supports being displayed. See the new lightweight maternities, supports for geriatric patients, new orthopedic supports, abduction pillows, arm sleeves, hospital binders, cervical collars, traction apparatus —pelvis, leg and head. Representatives will be present to answer queries on these very effective agents.

CORECO RESEARCH CORP. — 76

WARNER-CHILCOTT LABORATORIES — 77

Warner-Chilcott Laboratories will feature: Pacatal, the new phrentorophic agent. Pacatal's tranquilizing effect is unique because it produces a deeper calm with sedation. In depressed patients, Pacatal unlike other ataratic agents, produces a decided euphorogenic effect. Pacatal permits a normal active life to the tense, anxious or disturbed patient. Side effects are minimal with Pacatal, and its dosage schedule is simple and convenient for the patients.

Peritrate Sustained Action is a new dosage from the long-acting coronary vasodilatator. For the first time the angina patient is provided with round-the-clock protection against attack.

AYERST LABORATORIES — 78

Physicians are invited to visit Booth No. 78 where Ayerst representatives will be on hand to welcome them and discuss any Ayerst specialties of interest to them.

FLORIDA BRACE CORP. — 79

WALKER LABORATORIES — 80

VIACETS, HEDULIN, BACIMYCIN PRODUCTS, PRECALCIN and PRECALCIN LACTATE will be displayed at the WALKER Booth. VIACETS are multivitamin chewable CANDISPHERES available in five fresh fruit flavors—each flavor presented in its own color. HEDULIN is the oral anticoagulant described in recent papers and complete reprint portfolios will be available to all registered physicians.

A. S. ALOE CO. — 81

A cordial welcome is extended to the members of the Florida Medical Association to visit the A. S. Aloe Company exhibit. A unique array of Surgical, Physio-Therapy, X-Ray and Laboratory equipment will be displayed.

ELI LILLY AND CO. — 82

You are cordially invited to visit the Lilly exhibit. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

HOLLAND-RANTOS CO., INC. — 83

Simplicity with security keynotes the Koromex exhibit; H-R representatives will gladly explain: . . . WHY patients can easily and correctly place KORO-FLEX DIAPHRAGMS; . . . SIGNIFICANT features of KOROMEX Vaginal Jelly when "jelly-alone" is advised;

. . . Three-fold effectiveness of NYLMERATE Jelly and Solution Concentrate; Clinical value, in minor skin disorders, of HOLLANDEX Silicone Ointment.

SANDOZ PHARMACEUTICALS — 84

Sandoz Pharmaceuticals cordially invites you to visit our display.

BELLERGAL: Space Tabs—assures around the clock control of functional complaints (example—menopause symptoms) in the periphery where they originate.

SANDOSTENE: Space Tabs around the clock control of itching and hay fever.

BepHan Space Tabs new approach to prolonged maintenance of low gastric acidity.

Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products.

ABBOTT LABORATORIES — 85

Members of the medical profession will be cordially welcomed at Abbott Laboratories' exhibit of leading specialties and new products. Our representatives will be available at the exhibit to give information on the products and to answer any questions you may have.

PITMAN-MOORE CO. — 86

Please accept our invitation to visit the Pitman-Moore booth. We are showing a new product that has intrigued and interested us for some time—and we believe your interest will more than match our own.

We also have product information on our well known specialties Novahistine and Neo-Polycin.

SANBORN CO. — 87

Featured at the Sanborn exhibit will be the new and outstandingly successful Model 300 VISETTE—a complete electrocardiograph of full diagnostic accuracy that weighs only 18 pounds. The familiar Model 51 Viso-Cardiette will also be available for comparison—as will the famous Sanborn Metabulator.

For those interested in research, full data will be available regarding Sanborn Recording Systems (single and multi-channel; direct, photographic and tape), Monitoring Oscilloscopes and Transducers.

UNASSIGNED — 88

ATLAS PHARMACEUTICAL LABS., INC. — 89

PEPSI COLA CO. — 90

HART DRUG CORP. — 91

ENCYCLOPAEDIA BRITANNICA, INC. — 92

UNASSIGNED — 93

UNASSIGNED — 94

SMITH, KLINE & FRENCH LABORATORIES — 95

S.K.F. Representatives will be happy to discuss with you two new long-acting products for ulcer and other G.I. disorders, 'DARBID' Tablets and 'COMBID' Spansule Capsules. 'DARBID' (isopropamide, S.K.F.) is a potent new anticholinergic with inherent long-lasting effects. 'COMBID' combines 'DARBID' with 'COMPAZINE' (S.K.F.'s outstanding tranquilizer and antiemetic) in sustained release form. Both products offer b.i.d. dosage convenience and protect the patient all day and all night. The S.K.F. Booth also features injectable solutions of 'COMPAZINE' and 'THORAZINE' in the new MULTIPLE DOSE VIALS.

HOFFMANN-LAROCHE, INC. — 96

PARKE DAVIS & CO. — 97

Medical service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

AMERICAN FERMENT CO., INC. — 98

PFIZER LABORATORIES — 99

The Pfizer exhibit spotlights its recent and original therapeutic concepts represented by SIGNEMYCIN V CAPSULES, a combination of oleandomycin and tetracycline phosphate buffered; Signemycin I.V.; ATARAX-OID, the first ataraxic-corticoid; TETRABON V, the orange flavored phosphate buffered tetracycline syrup; MAGNACORT and NEO-MAGNACORT, the first water soluble corticoid; and LINODOXINE CAPSULES and EMULSION, the new Pfizer hypocholesterolemic agent.

C. V. MOSBY CO. — 100

The C. V. Mosby Company invites physicians attending the Florida Medical Association Meeting to inspect a score or more of new titles on display. Included among these new titles will be the following brand new releases: Williamson "Practical Use of Office Laboratory and X-Ray," Ryan "Headache," Lisser-Escamilla "Atlas of Clinical Endocrinology," Allen "Symposium on Strabismus," Forster "Modern Therapy in Neurology," Ball "Gynecologic Surgery and Urology," Kenney-Larson "Orthopedics for the General Practice," Jacobi-Hagen "X-Ray Technology," Sherman-Kessler" Allergy in Pediatric Practice," Modell "Drugs of Choice," Patton "Pediatric Index," Miale "Laboratory Medicine—Hematology," Willson "Obstetrics and Gynecology," Burdette "Etiology and Treatment of Leukemia," Stephenson "Cardiac Arrest and Resuscitation" and Morris-Scully "Endocrine Pathology of the Ovary.

EATON LABORATORIES — 101

Furadantin®, a specific for urinary tract infections, provides rapid bactericidal action against a wide range of gram-positive and gram-negative bacteria and organisms resistant to other agents including Proteus and certain strains of Pseudomonas. In six years of extensive use in the treatment of genitourinary tract infections, development of bacterial resistance remains negligible with Furadantin.

An advance in the treatment of vaginitis—Tricofuron® Improved Vaginal Suppositories and Powder. Simple two-step treatment swiftly brings relief and control of vaginal moniliasis and trichomoniasis. Rapid relief of burning and itching often within 24 hours. Eliminates malodor, esthetically acceptable.

NORDMARK PHARMACEUTICAL LABORATORIES, INC. — 102

LEVONOR, a new compound for suppression of appetite without C.N.S. over-stimulation, will be featured. The smooth action of LEVONOR permits its use during evening hours; it may be given as late as 8 P.M. without interfering with sleep. Also, recent reprints of clinical studies on FERRONORD will be available. Ferroglycine sulfate provides more rapid hemoglobin response with virtually no undesirable side-effects.

ZENITH RADIO CORP. — 103



BAXTER LABORATORIES, INC. — 104

WESTWOOD PHARMACEUTICALS
DIVISION OF FOSTER-MILBURN CO. — 105

FOSTEX CREAM and FOSTEX CAKE are new, easy to use, therapeutically effective medications for the treatment of acne, dandruff and seborrheic dermatitis. They contain Sebulytic® (lauryl sulfoacetate, alkyl aryl

polyether sulfonate, and dioctyl sulfosuccinate), a unique combination of penetrating anionic soapless cleansers and wetting agents which are highly antiseborrheic and exert antibacterial and keratolutic effects . . enhanced by sulfur, salicylic acid and hexachlorophene.

Fostex Cream is applied as a therapeutic skin wash in the initial treatment of acne, when maximum degreasing and peeling are desired. Fostex Cake is used as a therapeutic skin wash for maintenance therapy to keep the skin dry and substantially free of comedones. Fostex Cream is also used as a therapeutic shampoo in dandruff.

RIKER LABORATORIES — 106

Riker Laboratories presents DISIPAL, a new spasmolytic drug for skeletal muscle spasm and rigidity of Parkinsonism. Orally effective, long-lasting, minimal side actions, non-soporific and no known contraindications. Our exhibit also features its list of pioneering firsts: RAUWILOID (alseroxylon) and its combinations in the management of hypertension; PENTOXYLON in angina pectoris; MEDIHALER-EPI and MEDIHALER-ISO, measured-dose aerosol nebulization for effective asthma control. Visit Booth 106 for complete information.

JOSEPH E. SEAGRAM & SONS, INC. — 107

CONGENERS: MEANING—ANALYSIS

Congeners (fusel oil, aldehydes, acids, etc.) are compounds found in all alcoholic beverages that provide the taste, bouquet and color. In too high concentrations, however, they can cause undesirable after effects. This exhibit, based on analyses by Foster D. Snell, Inc., consulting chemists, shows how leading brands of various alcoholic beverage types differ in their congeneric concentration. Physicians who advise moderate drinking for some of their patients, can be guided by these findings.

CONTINENTAL X-RAY CORP.
STANDARD X-RAY CO. — 108

J. B. LIPPINCOTT CO. — 109

PET MILK CO. — 110

J. A. MAJORS CO. — 111

The latest editions of W. B. Saunders Company's publications will be available for your examination: Levine-Clinical Heart Disease; 1958 Current Therapy; Andresen-Office Gastroenterology; Orr-Operations in General Surgery and many others. Mr. G. E. Finch in charge.

ANDERSON SURGICAL SUPPLY CO. — 112

Be sure and come by Anderson Surgical Supply Company's Booth #112 and meet the "Baroness."

KNOLL PHARMACEUTICAL CO. — 113

VITA-METRAZOL is indicated where apathy is the predominating symptom. It improves appetite, regulates sleep pattern and increases sociability. VITA-METRAZOL is METRAZOL Liquidum with prophylactic amounts of selective Vitamin B complex components.

Information concerning VITA-METRAZOL as well as QUADRINAL, DILAUDID and the other KNOLL preparations is available for your review.

UNASSIGNED — 114

LLOYD BROTHERS, INC. — 115

RONCOVITE-MF, DOXINATE, and DOXINATE with DANTHRON, original products of Lloyd research, will be featured at this display.

RONCOVITE-MF provides the new concept of complete anemia therapy due to the unique marrow activating effect of theapeutic cobalt, acting through erythropoietin (the erythropoietic hormone).

The DOXINATE family of products affords the physician a complete choice of medication for the management of all types of constipation.

UNASSIGNED — 116

MEDICAL PROTECTIVE CO. — 117

MALPRACTICE PROPHYLAXIS . . . Professional Protection Exclusively by The Medical Protective Company achieves new records of security for the doctor. Complete program of PREVENTION, DEFENSE and PROPER PROTECTION against LOSS has reduced average per capita incidence of suits to less than one-third that of 30 years ago. "Specialized Service makes our doctor safer."

BRAYTEN PHARMACEUTICAL CO. — 118

THE NATIONAL DRUG CO. — 119

The National Drug Company exhibit highlights PARENZYME AQUEOUS and PARENZYME B (Buccal). The efficiency of the anti-inflammatory, anti-edema agents PARENZYME AQUEOUS and PARENZYME B is clearly substantiated for the treatment of traumatic wounds, ulceration, phlebitis, ocular inflammation and for loosening of bronchial plugs in severe pulmonary disease. Our representatives anticipate discussing with you the latest advance in Enzyme therapy in the form of PARENZYME B (Buccal).

RITTER CO., INC. — 120-121

This preferred Ritter office equipment enables you to treat *more* patients *more* thoroughly with *less* effort in *less* time.

More and more Physicians are finding routine examinations and treatments in Gynecology, Proctology, Urology, E.E.N.T., and all other phases of Medicine, easier through using Ritter Motor Operated 'Multi-level' Tables.

Visit the Ritter display and let us demonstrate and explain to you the many benefits derived from this investment in a lifetime of convenience and comfort for both doctor and patient.

TABLEROCK LABORATORIES — 122

Table Rock Laboratories has been serving the Medical Profession in the southeast for 30 years. We have developed many drug specialties, the best known being BISMUTH VIOLET. Other valuable contributions include: TABOREA, first of its kind, a daytime sedative; DILOCOL, another first in its field for cough control; SEDALGESIC, non-narcotic, non-barbiturate analygesic and sedative; and SENAZOL, a geriatric hormone tonic. We greatly appreciate the Profession's support.

ROSS LABORATORIES — 123

ROSS LABORATORIES: CURRENT CONCEPTS IN PEDIATRICS stressing the critical aspects of preventive care and the development of the infant as a whole being. Your SIMILAC representative will be happy to discuss the role of physiologic feeding in providing optimum clinical benefits. Copies of the latest Ross Pediatric Research Conference Reports are displayed.

BURROUGHS WELLCOME & CO. — 124

The extensive research facilities of 'B. W. & Co.', both here and in other countries, are directed to the development of improved therapeutic agents and techniques.

An informed staff will be at our booth to discuss our products and latest developments.

WINTHROP LABORATORIES — 125

Dilcoron, a new "flavor-timed," dual-action, coronary vasodilator for angina pectoris; orally for dependable prophylaxis and sublingually for immediate relief. The sublingual—oral tablet has a quick acting layer of nitroglycerin 0.4 mg. over a central core of prolonged acting pentaerythritol tetranitrate 15 mg.

GEIGY PHARMACEUTICALS — 126

The Geigy exhibit will feature BUTAZOLIDIN and BUTAZOLIDIN-ALKA, potent non-hormonal antiarthritic and anti-inflammatory agent also effective in the treatment of superficial thrombophlebitis; and PRELUDIN, non-amphetamine appetite suppressant virtually without CNS stimulation. Also on display will be STEROSAN HYDROCORTISONE Cream and Ointment, for comprehensive control of a wider range of dermatoses; MEDOMIN, the hypnotic which provides "natural" sleep; and SINTROM, potent oral anticoagulant with intermediate duration of action.

KREMERS-URBAN CO. — 127

The Kremers-Urban booth will feature the ultimate in smooth dependable spasmolytic-sedative timed release therapy, LEVSINEX/PHENOBARBITAL Extended Action Tablets. MILKINOL, modern constipation corrector for all age groups . . . KUTAPRESSIN for rebellious skin diseases and in prevention of capillary hemorrhage.

EISELE & CO. — 128

Eisele & Co. will display their regular line of Hypodermic Syringes, both Regular and Interchangeable, Clinical Thermometers, and Hypodermic Needles. In addition Eisele & Co. will display their line of Eco Bandages and Specialty Glassware.

A. H. ROBINS CO., INC. — 129

KELEKET X-RAY OF FLORIDA — 130

Keleket X-Ray of Florida will have on exhibit the new Philips Surgex apparatus with the electronic image intensifier.

This is one of the physicians most valuable mobile x-ray diagnostic tools in surgery, x-ray department and emergency room.

With the introduction of the image intensifier, fluoroscopy can be done at a safe radiation level (½ MA) and without dark adapting the eyes.

Applications: Hip pinning, fluoroscopy and spot radiography. Exact locating of tumors prior to x-ray therapy. Emergency Room fluoroscopy.

Moving picture films of unique uses of apparatus will will be shown during the convention.

Hans B. Heether

SURGICAL SUPPLY CO. — 131

G. D. SEARLE & CO. — 132

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Enovid, the new synthetic steroid for treatment of various menstrual disorders; Zanchol, a new biliary abstergent; Nilevar, the new anabolic agent, and Rolicton, a new safe, non-mercurial oral diuretic.

Also featured, will be Vallestril, the new synthetic estrogen with extremely low incidence of side reactions; Pro-Banthine, the standard in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

CHARLES C. HASKELL & CO., INC. — 133

Representative will be present to welcome visiting physicians and to answer any inquiries regarding our ethical prescription specialties, such as our BELBARB family (sedative-spasmolytic), HASAMAL-HASACODE (analgesic), IROSUL-C (hematinic with vitamin C), PANTABEEROID (thyroid therapy), and other rational therapeutic combinations.

ARLINGTON-FUNK LABORATORIES DIVISION
U. S. VITAMIN CORP. — 134

Exhibit features C.V.P., an exclusive water-soluble citrus bioflavonoid compound with ascorbic acid . . . for restoring and maintaining capillary integrity. Corrects or minimizes capillary abnormality and bleeding associated with diabetes, hypertension, epistaxis, purpura, gingivitis and certain forms of gastro-intestinal, rectal and vaginal bleeding. Effective therapy in habitual and threatened abortion.

Professional samples and literature distributed also on our complete line of nutritional and pharmaceutical specialties.

PARCO SURGICAL SUPPLIES — 135

MEDICAL SUPPLY COMPANY OF JACKSONVILLE — 136

E. R. SQUIBB & SONS — 137

C. B. FLEET CO., INC. — 138

Fleet will exhibit CLYSMATHANE, its most recent contribution in the field of medication by rectum—an advanced method of xanthine therapy. CLYSMATHANE is a stable solution of theophylline monoethanolamine; easily retained; rapid and uniform absorption; prompt and predictable blood levels; with no rectal irritation after prolonged use. CLYSMATHANE, in a disposable rectal unit, makes self administration easy any time and any place—and assures prompt therapeutic blood levels. Examine the unit and ask for samples and literature.

MEDICAL SUPPLY CO. — 139

THE COCA-COLA CO. — 140

Ice-cold Coca-Cola served through the courtesy and cooperation of the Miami Coca-Cola Bottling Company, Miami, Florida and The Coca-Cola Company.

THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. Box 2411 Jacksonville, Florida

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Association's Annual Convention
Bal Harbour. May 10-14, 1958

When the Eighty-Fourth Annual Meeting of the Florida Medical Association convenes next month, it will be meeting for the fourteenth time in the Greater Miami area. The dates this year are May 10 to 14, and the place is the Bal Harbour section of Miami Beach. The headquarters is the fabulous resort hotel, the Americana —Hotel of the Americas. Dedicated to the art and culture of the 21 nations of the Western Hemisphere, this new cosmopolitan oceanfront hotel offers a unique setting and is ideally appointed to serve the Association for its annual gathering.

Conforming to the schedule instituted last year, the first session of the House of Delegates will take place on Sunday afternoon, May 11, in the Bal Masque Room of the hotel from 3 to 5 o'clock. No other meetings will be held that afternoon. All specialty groups will hold their meetings on Saturday and on Sunday morning and evening.

The Association will be honored by the presence of Dr. David B. Allman, of Atlantic City, N. J., President of the American Medical Association. "Is the Game Worth the Candle?" is the title of the address he will present at the General Session, which will convene at 9:30 on Monday morning. The special guest speaker who comes at the invitation of President Roberts is O. W. Hyman, Ph.D., of Memphis, Tenn., Dean of the College of Medicine and Vice President in charge of Medical Units of the University of Tennessee. He has chosen the timely subject, "The Greatest Problem of Medical Education and Its Relation to Medical Practice" for his address on Monday morning. Also scheduled to address the General Session is Dr. J. Rocher Chappell, of Orlando, whose subject is "Civil Defense, Past, Present and Future." Dr. Chappell is the chairman of the Association's Committee on Civil Defense and Disaster.

Following last year's innovation, the whole day on Tuesday will be devoted to two scientific sessions. The entire scientific program for the convention will be presented at these two sessions. Sixteen members of the Association will preside, pre-



Dr. Allman



Dr. Hume



Dr. Chappell



Dr. Smith

sent papers, moderate, or serve on panels. Two distinguished guest speakers will present scientific addresses. Dr. David M. Hume, of Richmond, Va., Chairman of the Department of Surgery of the Medical College of Virginia, will speak on "Organ Transplantation — Past, Present and Future," and Dr. David T. Smith, of Durham, N. C., Chairman of the Department of Bacteriology of Duke University School of Medicine, has selected for his subject "The Role of the General Physician in the Changing Picture of Tuberculosis."

The second session of the House of Delegates will be the concluding session of the convention. It will take place on Wednesday morning.

The President's Reception is scheduled for 6:30 on Monday evening. The annual dinner, omitted last year, will be resumed this year at 8 p.m. on Tuesday.

The scientific and technical exhibits are of perennial interest. They are particularly good this year and will be a popular attraction. The added attractions of the recreational facilities of the resort area give promise of a convention no member of the Association will want to miss.

Orren Williams Hyman, Guest Speaker

Orren Williams Hyman, Ph.D., of Memphis, Tenn., is a native of North Carolina. The son of Aquilla Pierce and Margaret Williams Hyman, he was born in Tarboro on Dec. 21, 1890.

Dr. Hyman attended the University of North Carolina, where he was awarded the A.B. degree in 1910 and the M.A. degree in 1911. Princeton University conferred upon him the Ph.D. degree in 1921, and Southwestern College in Memphis honored him with the L.L.D. degree in 1938.

Making a career of teaching, Dr. Hyman served first as the principal of the public schools in Salisbury, N. C., for a year and then as Assistant Professor of Biology at the University of



Dr. Hyman

Mississippi the next year. In 1913 he joined the staff of the University of Tennessee College of Medicine in Memphis, as Assistant Professor of Histology and Embryology; he was advanced to Associate Professor in 1917 and to Professor in 1921, continuing in that capacity to the present time. Since 1925 he has been Dean of Administration of the Memphis Division of the University and Dean of the College of Medicine, and since 1948 he has served as Vice President of the University in charge of Medical Units.

During the 45 years of his association with the University of Tennessee College of Medicine, Dr. Hyman has contributed numerous articles to medical journals.

Dr. Hyman was married in 1921 to Miss Jane Johnston. They have three children, a daughter and two sons.

Is It Martyrdom To Serve?

How long can we attract young men to our organization if they see disadvantages rather than advantages in serving their medical association? Are we making it practically impossible for conscientious young physicians to serve?

Time was when it was an honor to serve as an officer, an editor, a delegate, a committee chairman, or a member of one of the working boards or committees of the Florida Medical Association, the county medical societies and allied groups. Those who served were rewarded by a show of appreciation on the part of their fellow members. Times change, but we question how much for the better in our particular case.

Too often in the recent past we have seen subversives gain control of important organizations in our nation because of the laissez-faire attitude of "Let John do it." Already inroads have been made in medicine on the same basis. Service in our organizations is a gratifying experience in itself, but with the possible exception of some who are financially independent, the physician of today depends upon the practice of medicine for his livelihood. Anything that interferes with that practice must warn him of possible disaster. Today's trend of rewarding work with more work with little regard for individual problems is discouraging the individual we need from participating in our affairs.

It is not a healthy attitude to have no competition for our higher offices. Too soon it may become necessary for us to coax doctors to run in order to fill a position.

Today organized medicine is BIG. It had to become strong to prevent us from being engulfed by government and labor, and even management in many cases. We must be ever alert to watch for new inroads on our way of life. We must be prepared to counter these with positive measures.

What is wrong? How can these practices be remedied? Primarily, we believe some show of appreciation must make it rewarding for those who serve. Let them know that you are familiar with what they do and that you approve or disapprove, but also that you appreciate their efforts. And try to be a little familiar with those efforts.

Much is now being said about paying the expenses of those who go away from home on work for our organization. This will be a help, but it can mean great expense to the Florida Medical Association, even to the point of an increase in dues if carried far. It is small recompense, however, to the individual doctor who has given of his time and talents. The loss of time with patients is the great cost to him. Repeated trips away on medical association business can ruin his practice unless his medical colleagues are thoughtful enough to see that the loss of patients is more than made up when he returns. It is not suggested that incompetents be benefited in this way, but be sure to become familiar with the professional work of the "working doctor" and see that he is not penalized for his service.

Unfortunately, an opposite attitude is too often practiced today. Doctors have even been heard to say "I might send that patient to John Doe, but John is too busy with medical association affairs." So the patient goes to a doctor who concerns himself only with his own affairs. Few things can do more to wreck our way of life. Fortunately, some who work are dedicated individuals and are willing to endure hurts and hardships, but must we make martyrs of those who serve us most?

Program of Annual Convention

The complete program of the Eighty-Fourth Annual Convention of the Florida Medical Association being held May 10-14 at Bal Harbour on north Miami Beach is published in this issue of The Journal beginning on page 1107.

The County Medical Society Lay Executive Secretary

A select group of the laity has in recent years established itself within the structure of organized medicine and, in ever growing numbers, has made for itself an enviable place in guiding the profession's greatly broadened activities. Less than a quarter of a century ago, most medical societies found the part time voluntary services of their elected physician-secretary sufficient to transact what little business there was between regular society meetings. Hardly a score of county societies and only three or four state associations at that time employed executive secretaries, most of whom were laymen. The profession as a whole was uncertain, even mistrustful, of the idea of laymen becoming affiliated with its organizational pattern.[1]

As medicine's activities rapidly broadened and its administrative problems became increasingly complex, more and more state and county societies employed full time nonmedical directors to manage their business affairs and coordinate their programs. Within two decades the attitude of the profession has been so completely reversed that today all but a handful of the state societies and most of the larger county units employ lay executive secretaries. Initially, the medical societies chose well, so well, in fact, that almost without exception their executive secretaries earned their admiration, confidence, respect and often genuine affection.

The lay executive secretary is today assured of a permanent place in the world of medicine. The men and women serving in this capacity have earned the distinction now accorded them and are making a unique contribution to the profession. The demand for their services in county medical societies grows steadily as the activities and responsibilities of these organizations continue to increase. A recent survey showed that 121 county societies employed a full time executive secretary, an increase of 54 over the 67 employed two years earlier.[2] Approximately two-thirds of the societies having a membership of over 300 reported having an executive secretary. Significant gains, however, were apparent in the lay executive trend in all society membership groups, and three societies with less than 50 members employed an executive secretary.

Florida is fortunate to have four lay executive secretaries serving component county societies of the Florida Medical Association and doubtless soon will have others. It recently lost to Texas one such executive of national prominence, whose accomplishments were legion and will ever remain legendary, when Mr. John C. Lee, Executive Secretary of the Dade County Medical Association since 1953, resigned to assume a similar post with the Harris County Medical Association in Houston.

The Dade County Medical Association early this year welcomed Mr. M. John Hanni Jr. as its new Executive Secretary. A native of Youngstown, Ohio, where he was born in 1924, Mr. Hanni came to his Florida post from Cleveland. In that city he had served as executive secretary of the Academy of Medicine of Cleveland since 1953. After attending the State University of



Executive secretaries presently serving component societies of the Florida Medical Association include (left to right) Mr. Marshall Brainard, Duval; Mrs. Marie K. Crowell, Pinellas; Mr. M. John Hanni, Dade, and Mrs. Berneice T. Mathis, Orange.

Iowa as an air corps premeteorology cadet in 1943-1944 he continued his academic training at Ohio Wesleyan University, receiving the B.A. degree magna cum laude in 1948. His honorary fraternities are Phi Beta Kappa, Omicron Delta Kappa and Pi Delta Epsilon, and his social fraternity Phi Gamma Delta. In 1950 he was awarded the M.A. degree by Western Reserve University and for two years thereafter was Assistant Dean of Men at that institution. During World War II he was in the Army Air Corps for more than three years, serving with the Inspector General in the China theater. He has had experience in newspaper work and also in advertising and public relations in the industrial field. Mr. Hanni and his wife, the former Joan Thomas of Cleveland, have three sons — twins, Christopher and Jonathan aged seven, and Timothy, who is two years younger.

When the Orange County Medical Society decided in 1955 to establish a central office and publish a bulletin, it employed Mrs. Berneice T. Mathis as Executive Secretary and Managing Editor. A Floridian, Mrs. Mathis was born in Pomona Park in 1920 and received her academic training at Rollins College. In 1950, she became active in the radio field, writing and producing programs, one of which she originated for her two daughters and herself. She entered public relations work in 1954, serving as instructor and assistant to the director of the Central Florida Dale Carnegie Enterprises until she became associated with the Orange County Medical Society in May 1955.

Mrs. Marie K. Crowell is the Executive Secretary of the Pinellas County Medical Society, and the Managing Editor of its Picomeso Mail Bag. A native of St. Louis, Mo., Mrs. Crowell was interested in U.S.O. work there and served as a sponsor. She worked with the Red Cross and United Givers and was a Den Mother for Cub Scouts for five years. Before coming to St. Petersburg, she was associated with the New England Home, a child placing agency in Pittsfield, Mass.

Mr. Marshall Brainard, Executive Secretary of the Duval County Medical Society, has served in this capacity for three years. Born in Buffalo, N. Y., in 1918, he received his higher education in California. In 1939, the College of Business Administration of the University of California at Los Angeles conferred upon him the B.S. degree. He is a licensed public accountant and is the senior partner and manager of the Physicians Service Bureau of Jacksonville. He also serves the Florida Society of Anesthesiologists and the Florida Academy of General Practice in an executive capacity. He was recently elected a director of the Medical Dental Hospital Bureaus of America. The son of a practicing physician, Dr. Forest J. Brainard of San Fernando, Calif., he is married to Dorothy Brewster of Callahan, whose late father, Dr. Warren A. Brewster, was a country doctor of northern Florida. They have two children.

The lay executive in medicine at whatever level — county, state or national — is confronted with a delicate and a difficult task in accepting the challenge to serve largely as a bridge between medicine and the public. He is described as pursuing a career dedicated to providing competent service to medicine, serving best in a role of conspicuous anonymity, directing but never officiating, originating but never advocating, providing continuity of interest and growth, even though the official leadership of the society changes every year.[1] If imaginative and enough of a philosopher, the layman in this field has an unprecedented opportunity to interpret his medical associates and their objectives and endeavors to the laity and, in turn, to lead them to a better understanding of lay reaction to them and their society undertakings. In addition, he renders invaluable service in providing coordination of function among the many volunteer officers and committeemen who serve their medical society. As coordinator within the society and between the society and the public, the gifted and competent lay exceutive secretary has much to offer any county medical society large enough to warrant and afford his services.

1.—Bryan, James E.: Public Relations in Medical Practice, Baltimore, The Williams & Wilkins Company, 1954, pp. 195-196.
2.—American Medical Association: 1955 Nationwide Survey on County Medical Society Activities, pp. 17-18.

First Permanent Disability Guide Published

In a special edition of The Journal of the American Medical Association, issued on Feb. 15, 1958, there appeared A Guide to the Evaluation of Permanent Impairment of the Extremities and Back by the Committee on Medical Rating of Physical Impairment. This committee is an ad hoc committee of the Board of Trustees of the American Medical Association appointed in September 1956 and authorized to establish guides for the rating of physical impairment. This 115

page publication is the first in a series of such guides which the committee expects to develop with the assistance of outstanding consultants. It is the purpose in this and future reports of the committee to correct a past confusion of terms and to provide practical guidance to the evaluation of various types of permanent impairments.

In dealing with this difficult and complex subject, much confusion has resulted from inadequate understanding by physicians and others of the scope of medical responsibility in the evaluation of permanent disability and the difference between permanent disability and permanent impairment. It is obviously vitally important for every physician to be aware of his proper role in the evaluation of permanent disability under any private or public program for the disabled. It is equally important for him to have the necessary authoritative material to assist him in fulfilling his particular responsibility in a competent manner. This series of guides is a service of inestimable value to the entire profession, and the first volume affords an excellent example of a task superbly rendered and offers a promise of future guides of equal value. The committee deserves the highest commendation and encouragement in this difficult undertaking.

A. M. A. Administrative Changes

Following a management survey in the spring of 1957, made by Robert Heller and Associates of Cleveland, the American Medical Association set about initiating certain organizational changes. Effective on Jan. 1, 1958, Dr. George F. Lull of Chicago was elevated to the newly created position of assistant to the president of the Association. For 11 years Dr. Lull had served as secretary–general manager and he will continue until June serving as secretary, which is an elective office. In his new post, his experience will be invaluable as he relieves the Association's president of many of the ever increasing burdens of that office and applies his talents and skill to solving medical problems at the state and local as well as the national level.

Dr. Lull, now 70 years of age, had a distinguished career in the Army before joining the A. M. A. staff. Entering as a first lieutenant in 1912, he emerged as a major general of the Army Medical Corps 34 years later. His last position before retirement was deputy surgeon general of the Army. During both World Wars he received many honors, including the Distinguished Service Medal. In 1951, the Cuban government gave him its highest honor, the Order of Carlos Findlay, for his humanitarian work in the field of medicine. Florida medicine honors Dr. Lull for his outstanding service and achievements and wishes him well in his important new post.

Succeeding Dr. Lull as general manager and busily engaged in his new duties since the first of the year is Dr. F. J. L. Blasingame of Wharton, Texas. It is expected that final action will be taken at the June meeting of the A. M. A. House of Delegates eliminating the title 'general manager' and substituting the title 'executive vice president,' thereby making Dr. Blasingame the first to bear the new title.

Active in state and national medical affairs for many years, he takes over this key position at the age of 50. When the A. M. A. House of Delegates elected him as a member of the Board of Trustees in 1949, he was one of the youngest physicians ever chosen for membership in that body. Since that time he has held many important A. M. A. committee appointments and has represented the A. M. A. at several world conferences of the World Medical Association abroad. In 1955 he served as president of the Texas State Medical Association.

Teaching and medical education hold particular interest for Dr. Blasingame. Upon graduation from the University of Texas Medical School at Galveston in 1928, he taught there for three years and thereafter maintained teaching connection at the University of Texas. He is chairman of the medical advisory board of the Sears-Roebuck Foundation, which encourages young doctors to create new medical facilities where they are needed. At the time of his appointment to the A. M. A. executive post, he was president of Blue Cross–Blue Shield Plans of Texas, and for 20 years had engaged in private practice in the same location. Young, highly experienced, he has made the change at great personal sacrifice to dedicate himself to American medicine as a whole and to the principles of good medical care for all of the American people. Possessing all the essentials of leadership, plus knowledge, imagination and sound thinking, he has the courage and initiative to shoulder responsibility. The Florida Medical Association salutes Dr. Blasingame and congratulates the American Medical Association on its wise choice of a chief executive officer.

The special House committee, headed by Dr. William A. Hyland of Grand Rapids, Mich., which had spent months studying the Heller report, submitted its recommendations on improving the A. M. A.'s organizational structure at the Clinical Meeting in Philadelphia last December. The House disapproved only one of these recommendations, voting that the election of individual trustees should continue to be based upon an at-large nationwide principle rather than upon representation from specific physician-population areas of the country as favored by the Heller report and the Hyland committee. Recommendations approved by the House included combining the offices of secretary and treasurer into a post to be filled by a trustee; discontinuing the post of general manager in favor of an appointive Executive Vice-President as chief staff executive; and creating a joint House-Trustees committee to redefine "the central concept of A. M. A. objectives and basic programs," to place more emphasis on scientific activities, to study socio-economic problems, and to take the lead in "creating more cohesion among national medical societies." These constructive measures are noted with interest and gratification by the component state medical societies and should redound to the benefit of American medicine as a whole.

Florida Medical Foundation Progress Report

The Florida Medical Foundation was established by the Board of Governors of the Florida Medical Association at the direction of the House of Delegates. This nonprofit organization, which became operative last year, has for its purpose the promotion of better medical care in Florida. Its officers now report a successful first year marked by several milestones of progress.

A major accomplishment was the execution of a trust agreement with the Florida National Bank of Jacksonville. By this agreement, the Foundation designates the bank as Trustee to receive such property as the Foundation wishes to turn over to it to be handled, managed, invested and distributed as directed in the trust instrument. Additional properties may be added by the Foundation or may be accepted by the Trustee direct from other sources, if for purposes acceptable to the Foundation. If specific purposes are designated by persons making donations or by the Foundation itself, the Trustee will, for convenience, administer the trust property in separate accounts. One division is general in nature, dealing with undirected funds which will be earmarked from time to time by direction from the Foundation. A second division relates to earmarked funds, as, for example, an amount, the income from which is to be used for a particular medical school, or a donation directed to research in cancer or some other disease. Any number of separate accounts will be kept by the Trustee in accordance with the directions of the donor or of the Foundation if the donor does not specify or is not sufficiently definite. This agreement assures the safest, most business-like, and most expeditious handling of the funds of the Foundation and should encourage many Association members and the laity to participate generously in the great philanthropic endeavor the Foundation is undertaking.

During the year, the Dade County Medical Association requested the Foundation to accept and administer its student loan fund. Accordingly, a letter agreement was drawn up consummating this noteworthy step by the Association's largest component county society. The streamlined agreement is similar to the trust agreement with the Florida National Bank and was drawn to permit the Dade County Medical Association to give the Foundation a sum of money to be administered in accordance with instructions in the letter.

The Madison County Medical Society is another component county society participating with enthusiasm in the Foundation program. All active members made contributions to the Foundation. The sum of $300, sent in by the Marion County Medical Society, was received so recently that it is not included in the financial statement here reviewed. The Foundation cause is one which promises to have steadily growing appeal to the county society as a group as well as to the individual members.

While a large sum of money is not involved in the first year's financial statement, the figures show a promising beginning in a worthy project now firmly established on a sound basis. Eight donations, ranging in amount from $25 to $200 and totaling $525, were received for and disbursed to medical schools in the name of the donor. The six donations designated for aid to needy medical students amounted to $1,793, of which $1,578 represented the Dade County Medical Association

Medical Student Loan Fund. A donation of $5 started the fund for assistance to destitute members of the Florida Medical Association, and two contributions totaling $110 were for sponsoring medical research. One donor sent in $700 to be used in furnishing a room in the Putnam County Hospital. There were 24 donations with no designation, which totaled $910. For the year 1957 a total of $4,043 was received.

The Foundation has retained as legal counsel the firm of Marks, Gray, Yates & Conroy and as certified public accountants the firm of Smoak, Davis & Nixon. Mr. W. Harold Parham was elected to serve as executive secretary.

The Board of Governors of the Association serves as the Board of Directors of the Foundation. The Foundation's nine objectives, as set forth in the charter, are:

1. The improvement of the health and medical care of the people of Florida.
2. The fostering and sponsorship of graduate and postgraduate medical education.
3. Financial aid for residents of Florida needing assistance who are pursuing an education in medicine.
4. The promotion of scientific knowledge in medicine among members of the medical profession.
5. The promotion of scientific knowledge in medicine between the medical profession and the public in Florida.
6. The promotion and sponsorship of medical research.
7. Assistance, through charitable acts, to deserving indigent and destitute members of the Florida Medical Association who shall be ill, incapacitated, or superannuated and in great need of aid.
8. The promotion among physicians of Florida of the principles of medical ethics.
9. Assistance to members of the Florida Medical Association, through a welfare defense fund, in defeating charges without merit of professional malpractice.

The Foundation welcomes donations to any one or any combination of these projects. It is also glad to accept undirected funds for use at the discretion of the Board of Directors for the objectives designated.

The programs of the specialty societies, meeting in conjunction with the Florida Medical Association at Bal Harbour, May 10-14, are published in this issue of The Journal.

Southern Railway Surgeons Meet in Jacksonville April 14-15, 1958

The Association of Surgeons of the Southern Railway System will hold its annual meeting at the George Washington Hotel in Jacksonville on April 14 and 15. This convention each year attracts some 150 physicians and their families from all of the Southern states east of the Mississippi River and from a few of the border states. The meeting was held in New Orleans last year. All members of the medical profession are invited to attend this meeting, and reservations may be obtained by writing the hotel.

Dr. Cecil E. Newell of Chattanooga, Tenn., President, will preside at the opening session on Monday morning. The program features a Symposium on Thoracic Trauma, presented by The J. Hillis Miller Health Center of the University of Florida, with Dr. E. R. Woodward, Professor and Chairman of the Department of Surgery of the College of Medicine, presiding. The other participants and their subjects are Dr. J. G. Wilson, Professor of Anatomy, "Anatomy and Mechanical Aspects of Respiration;" and Dr. W. W. Stead, Professor of Medicine, "Physiological Alterations in the Respiratory Mechanism Following Trauma." Dr. Woodward will conclude the Symposium with a lecture on "Therapy as Based on Anatomical and Physiological Considerations." Preceding the Symposium Dr. George Bunch of Columbia, S. C., will present a paper on "The Surgical Approach of Esophageal Hiatus Hernia," and following the Symposium Dr. Robert E. Mabe of Chattanooga, Tenn., will discuss "The Role of Anticoagulants in Vascular Disease." The concluding feature of the morning session will be the presidential address. Dr. Newell has chosen for his subject "Power Mower Injuries."

Dr. Rudolph M. Landry of Chattanooga, Tenn., will preside at the afternoon session on Monday. The program will open with a paper on "The Treatment of Recurrent Breast Cancer" by Dr. Carrington Williams Jr. of Richmond, Va., which will be followed by a paper entitled "Present Day Considerations of Thyroid Diseases," presented by Dr. Henry Poer of Atlanta, Ga. The University of Miami School of Medicine will then present a Symposium on Surgery of the Upper Gastrointestinal Tract, with Dr. John J. Farrell, Professor and Chairman of the Department of Surgery, presiding. The other partici-

pants and their subjects are Dr. Frank T. Kurzweg, Associate Professor of Surgery, "Physiologic Basis of Gastric Surgery," and Dr. Donald W. Smith, Clinical Professor of Surgery, "Alimentation in Gastric Surgery." Dr. Farrell will conclude with "Diagnosis and Management of Upper Gastrointestinal Hemorrhage." The session will close with "Interview and Examination of General Salling, 111-Year Old Confederate Veteran," a tape recording by Dr. John Dougherty of Knoxville, Tenn.

Four panels will constitute the program on Tuesday, April 15, three of them to be presented in the morning at the Duval Medical Center. The first one is a Vascular Clinic Panel, with Dr. Arthur R. Nelson of Jacksonville serving as moderator. The panel members are Drs. Woodward, Gainesville, John H. Terry, Jacksonville, Edward F. Parker, Associate Professor of Surgery, Medical College of South Carolina, Charleston, S. C., and Mason Romaine III, Jacksonville.

A Tumor Conference will follow, with Dr. F. Hardy Bowen of Jacksonville, Director of the Tumor Clinic at the Duval Medical Center, acting as moderator. Serving on the panel are Drs. Wilbur C. Sumner, Chairman of the Department of Surgery, Baptist Memorial Hospital, Benjamin J. Philips Jr., and Lauren M. Sompayrac, Chief of Dermatology, Duval Medical Center, all of Jacksonville, and Dr. Farrell, Miami.

A Diagnostic Medical and Surgical Conference, with Dr. Edward Jelks of Jacksonville serving as moderator, will conclude the Duval Medical Center program. Panel members are Drs. Mabe, Chattanooga, George T. Harrell Jr., Dean of the College of Medicine of the University of Florida, Gainesville, William H. Prioleau, Clinical Professor of Surgery, Medical College of the State of South Carolina, Charleston, S. C., Arthur Chenoweth, Associate Professor of Surgery, Medical College of Alabama, Birmingham, Ala., and Karl Hanson, Chief of the Department of Medicine, Baptist Memorial Hospital and Duval Medical Center, Jacksonville.

Following luncheon at the Duval Medical Center, the final session will be held at the hotel. "Man with Trauma Versus Trauma in Man—Back and Head Injuries" is the subject of the afternoon panel discussion. The moderator is Dr. John D. Ferrara, and the panel members are Drs. Frank L. Fort, James G. Lyerly, William H. McCullagh and G. Frederick Oetjen, all of Jacksonville.

Florida is fortunate to have this convention of surgeons with its excellent program within its borders. The meeting should evoke wide interest locally and statewide. Dr. F. Hardy Bowen is the chairman of the local committee on arrangements.

1957-1958 Fair Exhibits Attract Large Crowds

Demonstrating once more the public's keen interest in health and medicine, large crowds attended the Florida Medical Association's annual round of fair exhibits held during the 1957-1958 fall and winter fair seasons.

Featured in three appearances in Florida during the two fair seasons was the American Medical Association's newest exhibit, entitled "Digestion." The exhibit illustrates the anatomy and mechanics of the digestive processes by such means as a stomach model which moves in peristaltic action when an hand crank is turned.

Tallahassee was the scene of this exhibit's first display. Sponsored by the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, the exhibit drew wide public acclaim in the North Florida Fair, held Oct. 29-Nov. 2, 1957. Members of this society and its Woman's Auxiliary distributed some 3,000 voluntary health insurance pamphlets to visitors during the fair. More than 71,000 persons attended the five day display. In charge of the project was Dr. George H. Garmany, of Tallahassee, chairman of the society's committee on public relations. Woman's Auxiliary arrangements were supervised by Mrs. David J. McCulloch, also of Tallahassee, president of the group.



Th exhibit "Digestion" as shown at the Central Florida Fair at Orlando. The display was sponsored by the Orange County Medical Society with assistance by members of the Woman's Auxiliary.

metaphosphate produced markedly higher blood levels than capsules containing either the corresponding base or the hydrochloride alone. In addition, the average levels derived from the tetracycline base or the chlortetracycline base were higher than those produced by the corresponding hydrochloride though lower than those resulting from the mixture containing the base and sodium metaphosphate. In the study with chlortetracycline[6] capsules containing a mixture of the hydrochloride and sodium metaphosphate were also included in the crossover, and the average levels produced by these capsules were the same as with the mixture of chlortetracycline base with sodium metaphosphate.

Although the enhancement of blood levels of tetracycline by phosphate, either complexed to the tetracycline or mixed with the base or the hydrochloride, thus seemed fairly well established, some doubts still remained because certain reliable observers (including many whose results have not been published) failed to confirm the findings with the materials and methods they used. Further confusion seemed to be added by a subsequent report of Welch et al.,[7] who, in repeating a crossover study with capsules of tetracycline phosphate complex and tetracycline hydrochloride with and without sodium metaphosphate, found much hig

"...Tetracycline hydrochloride and citric acid, in an encapsulated mixture, produced higher serum concentrations and greater urinary excretions, and hence better absorption of tetracyclines, than any other preparation studied..."

...unavailable for ...

...ondum to the last mentioned paper of ... et al.[7] indicates that in their study the capsules of tetracycline hydrochloride, chlortetracycline hydrochloride and tetracycline phosphate complex all contained dicalcium phosphate as a filler, whereas the capsules containing citric acid and sodium hexametaphosphate did not contain any dicalcium phosphate. This could clearly explain the discrepancies noted in that study. Likewise, the inconsistencies in other studies may very well have been due to the presence of calcium as fillers in some of the capsules and not in others.

...e were published simultaneously with the last mentioned report of Welch et al.[7] These data were based on thoroughly controlled studies both in rats[8] and in man[9] and include additional findings that serve to explain, fairly conclusively, the various discrepancies that have been mentioned.

The experiments in rats[8] were carried out to study the effects of citric acid, dicalcium phosphate, sodium metaphosphate, food, oil and sorbitol on the serum antibacterial activity produced by the administration of tetracycline hydrochloride or tetracycline base. Citric acid administered in equal weight with tetracycline hydrochloride gave the highest concentrations of all the preparations studied. No enhancing effect was obtained from citric acid when given with tetracycline base. Dicalcium phosphate and food resulted in lower, and sodium metaphosphate in higher, serum antibacterial activity than was observed in their absence. Oil and sorbitol did not interfere with tetracycline absorption.

Dicalcium phosphate is widely used as a filler in various capsules, including those of the tetracyclines. The authors cite a large number of other studies that implicate the presence of calcium ions as the cause of the reduced absorption of tetracyclines and show that citric acid can partially neutralize this effect. The depressing effect of food on the serum levels of tetracycline is likewise explained by the goodly amount of minerals contained in commercial laboratory diets, and they postulate that the multivalent cations may be responsible for the poorer absorption of the drug. The authors could not explain the failure of citric acid to enhance serum concentrations when administered with tetracycline base in contrast to its marked effect when given as the hydrochloride. However, they hypothesized that the ability of citric acid to enhance serum levels of tetra...line is re... to its ability to form complexes ... en

This, however, fails to explain the most recent findings of Welch and Wright,[10] who compared the absorption of three capsules, each containing 250 mg. of oxytetracycline hydrochloride — one without any adjuvant, one with 250 mg. of citric acid and the third with 380 mg. of sodium hexametaphosphate; no other filler was contained in any of these capsules. In triple

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*Reg. U. S. Pat. Off.



The Hillsborough County Medical Association sponsored the exhibit "Digestion" at the Florida State Fair held at Tampa. Co-sponsor was the Florida Medical Association. Members of the county medical society spent some time at the exhibit each day to answer the questions of persons visiting the display.

The Florida State Fair in Tampa—the nation's largest winter exposition—provided the site of the second showing of the "Digestion" exhibit Feb. 4-15, 1958. The display was co-sponsored by the Florida Medical Association and the Hillsborough County Medical Association. Physicians were on hand to answer the many questions of persons visiting the exhibit. More than one million persons attend the sprawling State Fair each year. Members of the Woman's Auxiliary to the Hillsborough County Medical Association planned and installed attractive decorations in the display area. They also assisted in staffing the exhibit and passing out nearly 5,000 A.M.A. "Family Health Record" booklets. Dr. Malcolm D. Clayton Jr., of Tampa, chairman of the county society's committee on public service, supervised the project. He was assisted by Mrs. Leffie M. Carlton Jr., also of Tampa, president of the Woman's Auxiliary to the local society.

The final appearance of the "Digestion" exhibit in the state this year occurred in Orlando, Feb. 24-March 1, 1958, at the Central Florida Fair. The exhibit was sponsored by the Orange County Medical Society. Nearly 10,000 informational pamphlets were distributed to crowds visiting the fair by members of the Woman's Auxiliary to the county society, who also provided decorations for the exhibit space. In charge of the project was Dr. James A. McLeod, of Orlando. Mrs. Royston Miller, also of Orlando, president of the Woman's Auxiliary to the society, supervised the Auxiliary preparations.

Fifth Biennial Cardiovascular Seminar Miami, April 23-26, 1958

The Fifth Biennial Cardiovascular Seminar will begin on Wednesday, April 23, 1958, and continue through Saturday, April 26, at the DuPont Tarleton Hotel, DuPont Plaza Center, Biscayne Boulevard, in Miami. This Seminar is under the sponsorship of the Florida State Board of Health, The Florida Heart Association and the Heart Association of Greater Miami, Inc. By attending this meeting, members of the American Academy of General Practice will receive 18 hours of credit in Category II. The registration fee is $25.

This biennial gathering is one of the outstanding events in the cardiovascular field held in the South. The distinguished medical lecturers serving on this year's faculty are:

Michael E. DeBakey, M.D., Professor of Surgery, Baylor University College of Medicine, Houston; John B. Hickam, M.D., Associate Pro-

fessor of Medicine, Duke University School of Medicine, Durham, N. C.; Ancel Keys, Director of the Laboratory of Physiological Hygiene, University of Minnesota, Minneapolis; John W. Kirklin, M.D., Mayo Clinic, Rochester, Minn.; Chas. E. Kossmann, M.D., Associate Professer of Medicine, New York University College of Medicine, New York; Richard Langendorf, M.D., Research Associate, Michael Reese Hospital, Chicago; William Likoff, M.D., Associate Professor of Medicine, Hahnemann Medical College, Philadelphia; John H. Moyer, M.D., Professor of Medicine, Hahnemann Medical College, Philadelphia; and Robert W. Wilkins, M.D., Associate Professor of Medicine, Harvard Medical School, Boston.

BLUE SHIELD

Blue Shield — The Doctors' Plan

Frederick H. Good, M.D.
DENVER

President of Colorado Medical Service, Inc.

Blue Shield is big business. In 1955, voluntary prepayment amounted to $10,000,000 a day. Blue Shield averaged $1,400,000 a day. We think there will probably be a 15 per cent increase in those payments this year. The Blue Cross-Blue Shield building we are meeting in today is no two-by-four shanty we are dealing with; this is quite a structure, and it is not complete. In many ways, I doubt if it ever will be; we will keep adding rooms until we can comply with public demand. This is our Plan, it is a community project, it commands much community interest, and it is important that we take an interest in this program to guide and develop Blue Shield as best we can. Blue Shield started out as our baby, and it is a little frightening, sometimes a little obstreperous, but the Plan responds to guidance and reason. It is known throughout the land as the doctors' plan, and I think this is as it should be, because from Florida to every single Blue Shield Plan in the United States, it exists under the control of the medical profession.

Organization of Blue Shield

Let us go back quickly to the early development of Blue Shield. I would like to give you a run down on it, and some of the organizational setup. In 1942, Blue Shield operated in about 11 states. Now there are actually 73 Blue Shield Plans. As these Plans developed, it became obvious that some sort of a national organization was necessary because Blue Shield was operating in virgin territory. It was doing something that, as far as commercial insurance was concerned at that time, was not feasible, and certainly not insurable. Consequently, a national organization developed, which, as you undoubtedly know, is the Blue Shield Commission. This is made up of 33 elected commissioners; 22 from the districts (11 physicians and 11 Plan directors), eight at large, and three appointed and accepted by the American Medical Association. While this sounds complicated and it would appear that we were looking at Blue Shield through a maze of "gobble de gook," actually, Blue Shield functions fairly simply in its local autonomy. Every plan is autonomous and owes its primary loyalty to its own area. On the other hand, the national picture is growing with such rapidity, so much responsibility, that the demands and cooperation that must occur nationally cannot be ignored.

Types of Blue Shield Plans

There are several types of Blue Shield Plans. Forty-seven of them are partial service plans; in other words, that is service and indemnity. In Colorado, we would fall into that category because we operate two contracts. One has a $6,000 income limit, but if the individual makes over $6,000, the physician has the right and privilege to charge that patient more if he so desires. There are 18 indemnity plans and seven full service plans. With regard to this problem of service, while it is an intriguing area, it is dangerous to have the medical profession decide upon a given set of fees that it will accept irrespective of income. The big catch in it revolves around the fact that during an inflation in the economy, the doctor suddenly finds himself chained to static fees, the inflationary process proceeds, his overhead goes up, and he is dealing with what could ultimately be an intolerable situation. It is my personal feeling that a reasonable service income limit is to be desired. Service benefits are the one thing that justify the existence of Blue Shield. It is certainly the one

Information on pages 1137-1147 completes a series on the informational meeting of the Active Members of Blue Shield held in Jacksonville, Dec. 7, 1957.

thing that separates us from commercial carriers, and it does for the reason that only doctors can control, develop, distribute and change fee schedules. If we buy the service benefit principle, which is the greatest thing we have to offer as far as Blue Shield is concerned, we are immediately faced with another interesting point. It is extremely important that we have a service benefit contract, that we cover 80 to 85 per cent of our eligible subscribers. The reasons for that follow.

Importance of Adequate Service Benefit Contracts

First of all, as time goes on, and our economy rises, we will find ourselves in a position where our coverage does not reach 85 per cent. We are in that problem right now in Colorado. Our statewide fee schedule advisory committee is going to work next week on a $9,000 income limit, because after a study we found that we are covering, on the basis of this salary, approximately 65 per cent of our eligible subscribers. First of all, only doctors can determine fees, and these fees have to be fair and equitable for the service income limit that we are going to pick out. That is a must before our staff can determine any sort of a rate. On the other hand, in being fair and equitable, we are also faced with the responsibility that we do not get out in left field and start writing charges that will put the rate of our contract beyond the people that we are trying to serve.

Another thing is important. If 50 per cent of the subscribers are not covered, in other words, the income limit is inadequate, the doctor then has to secure an adequate fee, because the one that is in existence is usually inadequate. The doctor may then have to increase the fee anywhere from 50 to 75 to 100 per cent. This appears to the patient immediately as a tremendous mark up. The doctor does not want to do that because he may be embarrassed. He will take a smaller mark up, or he will take the inadequacy and be dissatisfied with what he has and think he is being inadequately paid. On the other hand, the patient objects to paying this additional fee because he thinks he has a service benefit contract, and his bill ought to be paid. Probably the most important part of all is that if we accept this situation in which 50 per cent or more of these subscribers are subjected to an additional charge, the very fundamental principle of the service benefit is defeated, and we are, in effect, dealing with an indemnity type of contract. The patient concludes that the doctors are sponsoring an inferior and inadequate product.

Along this line, I might mention the so-called 'no fee schedule.' Actually, to the best of my knowledge, there is no such thing as a 'no fee schedule.' There are fee schedules that are not published and for reasons that I think are reasonable. I think you would agree that you would not be much interested in going down to pick out a new car and say, "Well, I like that blue and red car. How much is it?" And the dealer says, "Oh, don't worry about that, I'll bill you when I get around to it. I'll see how many I sell this week; maybe it'll be more, maybe it'll be less." I am sure none of you hire a bookkeeper or receptionist on the basis of letting her determine her own salary month by month, related to how kind or indifferent you are, how many bills she has to get out, and how many phone calls she has to answer.

You may say that these two situations are not analogous, that in medicine, no two procedures are alike. Or, as I used to hear so frequently in Colorado, "Nobody's going to tell me what to charge." This last statement is a valid argument to a point. When we sit down to discuss problems with our patients, we take into consideration their economic status, their family problems, and a myriad of other things that are related to what they are able to pay. The charges are geared to that sort of a situation, and the patient generally insists on knowing what his obligations are. Now this is true just about the same as in a Blue Shield Plan. Before a rate is established, some concept must be formed of what the charges are going to be, because the rate is based on that problem. Once again, only doctors can decide. The doctor has to decide what is fair and equitable. Doctors have to be reasonable to keep this schedule in the area where it belongs.

Prepayment Without Fee Schedule a Misnomer

About the 'no fee schedule,' take for example the Wisconsin Plan. That is no blue sky deal. That is not a plan that exists so that the doctor has the opportunity to charge anything that comes to mind. The charges, in that situation, are geared to the usual charges in the area in which the service is rendered. In the Massachusetts prolonged illness type of coverage, for example, there is no published fee schedule, but the charges that are paid are those that are usual for the area in which the service is rendered. If you did not have that you would have to adjudicate every

single procedure on every bill that was submitted, and that would either have to be done by a committee of Blue Shield or a committee of the state society. Irrespective of who does it, the ultimate thing that occurs is the establishment of the fee. This fee has to be satisfactory to the patient, to the doctor and to the Blue Shield Plan. Commercial companies, on the other hand, with indemnity contracts, present a different situation. The difficulty in type of procedure needs bear absolutely no relation to the fees they pay, because all they are trying to do there is determine a cash payment on which they can establish a rate. I had a patient a month or two ago who came in with a fancy-looking insurance contract with a widely advertised commercial company that paid $750 for a pontine angle tumor and paid $25 for a cystocele and/or rectocele. This case points out that, in indemnity, there need be absolutely no relationship to the price in a procedure and the difficulty in performing the procedure.

Fee Schedule a Necessity

There is another area of debate and headache, the problem of the internist and medical service and the general practitioner. It revolves around this situation. The internists decided they did not want to be paid on a per diem allowance; they wanted to be paid a flat fee per case. The pediatricians were also interested in this, but not to the extent at that time that the internists were. Their society had several sessions, and I was invited to one where they were wrapping this thing up. The question arose, what about the general practitioner out at Wagon Wheel Gap, Colo., who sees a patient who says he has a coronary attack? Is he going to get $300 for that? Well no, they did not think he ought to get $300 because he was not a member of the Society of Internal Medicine. They could control him, however, because they had asked for the electrocardiograms, chest films, and the other laboratory procedures. They had decided what his payment should be. I said, "That's fine. I'll tell you what I'll do. I'll furnish the secretarial help, the stationery, and the postage and write letters for you, but one of you fellows in this group is going to sign the letter that tells that doctor that he isn't as good as you are and he only gets $200." They dropped it, and reconsidered it, and have now gone back to the sort of a schedule that we have. We pay $5 per day for 30 days and pay $3 per day for the next 40 days. In any three days of any given hospitalization, the doctor can receive an extra $20. In addition to that, if he still thinks that is inadequate, he has the right to petition the adjudication committee, which is made up of three pediatricians and three internists, and ask for more money, for which we have no maximum. Our experience has been rather limited with this plan, but so far it seems to be working very well, and we find no evidence of anyone abusing it.

Actually, I am not too concerned about having somebody tell me what I am going to charge, particularly if I can sit down with confreres and do it, because if we do not, I am sure somebody in Washington is going to do it for us. I am not as concerned about that as I am the fact that we as doctors generally do not like to do that. Our apathy is tremendous toward the idea of trying to sit down and get together and do a reasonable job on these fees, and yet that is the basic thing that we must do if this project is going to work. I would be the last one to say that every procedure is alike, but I also know that sometimes I get paid for something that is pretty easy and then I have a couple of tough ones. Taking the bitter with the sweet, it all seems to average out, and the fees are fair and equitable. There is absolutely no room in medicine today for 'pig in the poke' type of fee, any more than there is for a horse and buggy on a freeway. We are going to have to stand up and be counted. We are going to have to be responsible.

Blue Shield Not Truly Insurance

I think you will agree that Blue Shield is still growing. Some of you may say, "Well, this is all fine, but this is insurance, and doctors do not have any business in the insurance business." In the classical sense of the word, it is not insurance and I would bury that 'cliche' here today, once and for all, if I could. It is not insurance in my mind, and it is not even third party, for these reasons. First of all, we as doctors, control it. Secondly, it is a public trust, and the trustees serve without pay and in the public good. Thirdly, it is nonprofit. Fourth, since we control it, and it is a public trust, we hold the monies until there is proof of service, with the expenditures for overhead and the reserves being geared to a nonprofit corporation. In my mind, as long as doctors control it, it is not truly insurance and it is obviously not a third party problem.

Doctor's Sponsorship Important

The fact that it is not truly insurance is not

the only reason that Blue Shield is here to stay. The public acceptance and demand for this plan of ours has taken us far past the point of no return. There are 40 million people enrolled in Blue Shield. Figures like 40 million lead us to believe this is a going concern we talk about. On the other hand, this problem is far from solution because there are many people who are eligible for coverage who do not have it. I think one of the fundamental reasons for inadequate coverage revolves around the fact that people are not educated to budget for health insurance like they should be. They understand it better than they did when Blue Shield started, but they still have a long way to go. They are perfectly willing to go on the installment plan system for the TV set, a home, a boat, and a membership in the golf club, but when it comes to budgeting for health, this sort of leaves them cold, and they are prone to say, "Well, there aren't any good plans," or "The ones that are being sold are inadequate."

In 1955, the American public spent 28.6 billion dollars for being well. Yet in that same year, they spent only 9.1 billion dollars for well being. I think it is our responsibility to educate our patients and the people to the importance of budgeting for potential illness and sickness. In the old days you could stick a few dollars in the sugar bowl for the catastrophy that was going to happen, but I am sure all of you will agree that those days are long gone and the money that could be saved in that particular category is totally inadequate and unfeasible.

One way you can help in this problem of telling the Blue Shield story to your patients is to talk about its economic operation. Eighty-six per cent of every dollar of these 44 plans was returned as benefits to the subscriber. Roughly 9.7 per cent was used as overhead; the remainder was put in subscriber reserve. In contrast, let us consider three commercial companies, one of the best, the middle one, and one of the poorest. They pay 87 cents, 63 cents, and 45 cents on every dollar turned in. This, on the surface, looks excellent. The angle in the situation is that their group payments are a great deal better than their nongroup payments, which makes the picture look a little better. Blue Shield and Blue Cross, being community enterprises, have to take all comers and face all risks with little selection. I think you would be interested to know that out of 671 companies, 47 per cent of them paid 50 cents or less back for benefits. Do not get the idea that I am trying to infer that commercial insurance carriers in the medical-surgical hospital field are not competitive. They are extremely so. They are particularly so when it comes to group enrolment, because they have the ability to furnish a contract on experience rating and beat us to death in some of these areas. One thing they do not have, but would love to have, is the idea of doctors agreeing to a fee schedule, such as we do in Blue Shield.

Doctors Should Understand Feasibility of Expanding Coverage

Even though we are nonprofit, we have the responsibility of being careful about expansions, taking on new ideas and areas of coverage, so that we do not have an adverse experience. Along this line there are a couple of areas that are totally uninsurable on an unlimited fee for service basis, these being laboratory and x-ray procedure. Items to be insurable must fulfil several criteria, and these three are of major importance: first of all, the item must occur accidentally or fortuitously and not at the subscriber's election, in other words, per-chance; secondly, the item must be capable of reasonable, statistical prediction, therefore, predictable; and last, the item must be capable of proof. Thus these controls, plus the painful experience which is involved in an appendectomy, or in a multitude of surgical procedures, are the factors that make these items per-chance, predictable, and provable.

You might say, "What about the normal appendixes?" Well, I have taken out a few; I am sure there are some surgeons here who have done the same. I think doctors are fundamentally honest, and honest mistakes are being made. The painful experience in an appendectomy keeps the individual from seeking the use of his contract simply because he has a Blue Shield contract. And last of all, the present status of tissue committees in the hospitals can raise a question or two if surgical enthusiasm exceeds surgical judgment at times. While that appendectomy can be predicted and can be covered, you are stuck with the problem, for example, of trying to cover unlimited chest x-rays, or blood cell counts or blood sugar determinations. It is a difficult problem. Blue Shield is besieged by numerous demands for total care, house calls, prosthesis, nursing service, you name it. This is an attempt by the public to relieve themselves of all financial responsibility as far as illness is concerned. Such is actually impossible in our type of enterprise, unless you

have government intervention and control as some other countries have. What has happened, of course, is this idea of developing a major medical or catastrophic, or as I prefer to call it, prolonged type of illness coverage, in which the patient shares the risk along with the plan. Such coverage usually follows this sort of pattern: the basic Blue Cross and Blue Shield are written along with this prolonged illness rider. After Blue Cross and Blue Shield are used up, a corridor is developed, which the patient pays, and after this corridor is passed, then the rider or the plan usually steps back in and pays 85 per cent of the total bill, running it up to five, 10 or 15 thousand dollars or whatever sort of contract one wishes to write.

Doctors' Support Is the Deciding Factor

It is up to each and everyone of us to develop an interest in Blue Shield because, as I told you, Blue Shield represents two people, the patient and the doctor. We can ill afford to stand by idly criticizing without spending some of our time and our energy and our talent to become intimately acquainted with Blue Shield.

I am thankful that Blue Shield exists, because it is slowing down Uncle Sam from the standpoint of making further inroads in medicine. I do not think, however, that this is enough to justify our continued endorsement and participation in the development of Blue Shield. Even more important is the fact that here is a profession with a tremendously important economic tool, which, when properly used, is of great good and benefit to the public. I would also remind you that the day is long gone when Blue Shield is written for the low income group, or the medical indigent. Blue Shield can, should, and must provide suitable coverage to all people. It is up to us to devote the time and energy that is necessary to maintain the esteem and dignity that go with our stewardship of this doctor plan of ours.

Panel

Henry J. Babers Jr., M.D.
GAINESVILLE

The remainder of this program will be a panel discussion by the 17 committee members. The speakers on the panel are: Dr. James R. Boulware Jr., pediatrician from Lakeland; Dr. Henry L. Harrell, general practitioner from Ocala, who is the president of the Florida Academy of General Practice; Dr Donald F. Marion from Miami, an internist, who is president of the Florida Society of Internal Medicine; Dr. John S. Stewart, a radiologist from Ft. Myers; and Dr. Gretchen V. Squires, pathologist from Pensacola. I do not think anyone could say this panel was weighted in favor of the surgeon. Dr. Good is here also and following the panel, he will discuss any specific thing you suggest. We are not going to vote on anything, but you are welcome to make any remarks you wish following the panel discussion. Our various committee members represent practically all specialties and areas of Florida and they will answer any questions in reference to their own area. Dr. Whitman C. McConnell and I will act as coordinators for the panel.

James R. Boulware Jr., M.D.
LAKELAND

My subject is on two of the most important factors of Blue Shield.

1. Community Rates.—When Blue Shield's sister plan, Blue Cross, was originated, it based its rates on the simple fact that about one out of 10 persons needed hospital care each year and the average length of stay was 10 days. Using this concept, each person in the community paid for one day of hospital care per year, and there was enough money to pay for the average stay of the person who needed the care.

This simple principle still holds true today. Community rate did not segregate because of age and sex, and everyone paid the same rate for the same service.

Following the success of Blue Cross, based on community rate, doctors created Blue Shield, likewise based on one rate for the entire community.

In the beginning, with individual choice and some underwriting regulations, the persons enrolled in Blue Cross and Blue Shield were representative of the group. During the war years, individual choice was encouraged by employers allowing payroll deduction of dues and employer contribution toward the cost.

The picture changed when the employer or union entered the field and the insurance companies became interested in the good risks. The employer with a good risk group asked for a special rate, and the commercial insurance companies, which were afraid initially to deal with the unknown mass, were now prepared to encourage this and enroll the good risks. The insurance companies pulled and are pulling away the

good risks and leaving the poor risks so that they cannot support themselves.

Recent studies show that fewer persons in the lower income groups have health insurance than do those in the middle and higher brackets, even though persons in the low income groups have greater need for medical care. Should these lower income groups be further segregated, they would have to drop their insurance and turn to government or charity for their needed care.

A danger to us is that if we lose Blue Shield, the voice of the doctor will all but be stilled by the third party domination of unions and employers. They are now attempting to tell the doctor and the employees what care is to be made available and how this care is to be rendered.

2. SERVICE BENEFIT.—In the face of these dangers, there is one evident and optimistic fact and that is that we beat this before with community rate, and in the absence of competition, we were successful. We must find the means to keep the people in the community rate and we have the means in service benefits.

Service benefits protect everyone and crush segregation. Although developed primarily for the benefit of the patient, service benefits now have a real purpose for the doctor. Almost every buyer of insurance wants service benefits in preference to only dollar payment since service benefits assure him that the needed medical care will be paid for.

Service benefits attract to and retain within the community plan those good risks who would otherwise seek dollar advantages elsewhere. This is the reason why it is necessary not only to provide service benefits in our community plan, but also necessary to provide service benefits to a sufficiently representative group of the community so as to make certain that the good risks in the middle income group do not leave the community plan. If service benefits are made available only to a small group of low income people, the good risks and the poor risks of the low income group will be retained within the community plan, but those good risks of the middle income group who will not benefit by service benefits will be attracted to competition. Since higher proportions of good risks are in the middle income group, it is necessary to make service benefits available to them also.

We must support one plan, our plan, to assure that the doctors' voice will be heard and the persons who most need protection will have it available at a reasonable community rate.

HENRY L. HARRELL, M.D.
OCALA

Two weeks ago, in The Journal of the American Medical Association, there were four excellent articles written mostly by people in the commercial insurance fields. One of the articles brought out the fact that commercial insurance covers more people in hospital and medical care insurance than the Blue Plans do. In fact, it covers around 50 to 60 per cent. We know, however, that all such plans are indemnity plans, not service plans. Some commercial companies are getting into deductible Major Medical Insurance, and since these plans are gaining headway, it might be that they will come out with more of them.

I do not believe the public is quite ready for deductible insurance plans. At least, they are not ready around Ocala. These people want everything covered; they do not want to pay the first $25 themselves. In addition, they would much rather have an insurance that pays for diagnostic work, office calls and all that. Some people have plans that are pretty expensive, but they still buy them. For example, we will have to get something to fight this plan of Mr. Reuther's in Detroit, because it is true that some people who have such plans actually like them.

I had a chance to talk with some of the people in San Francisco who are under a closed panel there. You know it has been running for some years. It surprised me that people on this plan, including college graduates in research departments for the oil companies, had to go to closed panel physicians, and yet nearly all of them liked it. They thought I was unreasonable to argue against it. I brought out the idea of not being able to select their own physician, and they simply used the same argument we use for partners.

In the fee schedule we sent out recently, most of the people who received it refused to fill out anything not in their practice. They would not fill it out for surgeons if they were internists. They said, "We don't have anything to do with the surgeon's schedule." From looking at some of the schedules, I think it would have been better if the medical men had filled out the surgeon's schedule and vice versa. All of them seemed to have such exaggerated opinions of their own financial worth that it might have been better if the general practitioner had filled out all of them.

Donald F. Marion, M.D.

MIAMI

The remarks that I make are not to be interpreted as a narrow-minded point of view. They are not so intended. Sincere gratitude is expressed by everyone in this room to those who have spoken before. Their general tenor of thought appears to be just a little too optimistic to me. It appears to be a little too much of a eulogy. It seems to imply too much of take this or else. I am not altogether certain we have to take it. One point to think about, and possibly ask questions about, is this situation. The average man who does not perform surgery, and there are quite a number in Florida and in every other state, possibly might well wonder when his patient says, "Doctor, what's the best insurance plan for me to buy?" Is there not something to think about in the fact that any impersonal indemnity plan, no matter who runs it, does not ask whether the individual has a proved appendicitis or a proved meningitis. The average person who is seriously ill with meningitis often feels that he does not have a minor illness. As the Blue Plans are now set up, and if we attempt to expand the income level coverage for complete service coverage by the Blue Plans, we must be realistic, gentlemen, or we certainly are not going to sell them. We cannot tell the people they are going to have complete coverage on the service basis, and pay for their meningitis and their asthma at $3 a day. It cannot be done.

There can be no argument to the idea that doctors must agree and participate more or less equally according to their contributions to the service plans. At the present time, however, although it is politics that usually makes strange bed fellows, I think Blue Shield has made strange bed fellows. The medical man and the surgeon are in the same bed on the service contract; but the surgical man is getting most of the covers and the medical man is cold, and he is not happy about it. If we are to go on, as perhaps we must, to higher income ceilings for an across-the-board service contract, I wonder if we should not attempt a little better readjustment of participation.

John S. Stewart, M.D.

FT. MYERS

From 1940 through 1953 we have seen an increased utilization of hospitalization by our insured participants. In 1940, this was approximately 100 per thousand participants, but we are now up to around 159 and we are gradually increasing at the same ratio. The curve is rather steep, and the cost of hospitalization is going up. During this past year we had to ask the insurance commissioner for an increase in premium rates. We have heard many complaints about overutilization of hospitalization by our participants. We are constantly besieged locally by a clamor for more hospital beds. Back in 1940, we could build a pretty good hospital at $10,000 a bed; today it is $25,000 per bed. We need hospitalization for the critically ill. It seems to me that we ought to get it on both ends. We are going to get it from federal taxes increasing bed space throughout the states and we will get it from increased premium rates to our patients. As to what the answer to that problem is, I heard just a suggestion of an answer from Mr. Ketchum today. He said that in Michigan they are appointing regulatory committees; he called them police committees. I would hate to be on such a committee, but if that is what it is going to take to keep everybody honest, the patient and the doctor, maybe that is the solution to the problem of these increasing premium rates for our enrolled participants and our increased overutilization of the hospitals.

Gretchen V. Squires, M.D.

PENSACOLA

The most prominent complaints that we have from the physicians of Florida have been regarding the inequities of the Blue Shield fee schedule. One of the things the Committee of Seventeen was commissioned to do was to see what could be done about the fee schedule. The Florida Medical Association has a fee schedule committee, but we were supposed to get groundwork laid as to what were some of the things that could be done. I do not think anyone will argue the fact that for any given procedure there must be a price in relationship to its technical difficulty, the professional acumen necessary to perform satisfactorily the task, and the actual cost of completion of the procedure. That is something that must be set by a professional, a physician, and not by someone who is dealing, as an actuary does, with figures. Since these variables are within the scope of professional knowledge, it would seem to me that it is the responsibility of the physicians of the state, either individually or

through their representation on the Blue Shield Board of Directors, to agree on what is the relative value of procedures and, if possible, what is the absolute value of any given procedure.

Many of you signed your Blue Shield agreements about 11 years ago, and I would like to refresh your memory as to what you agreed. "In consideration of being accepted as a participating physician of Blue Shield of Florida, Inc., I do agree, 1. To perform the professional services, medical and/or surgical, specified in the subscription contracts issued, or that may be issued by the plan in accordance with accepted practices in the community, at the time the services are rendered and at such rates of compensation as shall be determined by the regulation of the plan, applicable to the participating physicians, a copy of which shall at all times be available in the office of the plan." You also had the privilege of cancelling the agreement on 30 day notice, or having the plan cancel its agreement with you, on similar notice. We stated back then that the rates of compensation should be determined by the plan, and the plan, as you see from this agenda, is primarily the physicians of the state. Now, if each practicing physician developed a schedule of fees that he would accept as full payment for the services he rendered his patient, and if the insurance carrier could sell such a contract, I presume the physician would then be satisfied with the fee he received as a full service benefit. That is a normal presumption, because he himself sets the fee. The transaction would have no such inflammatory term as "service benefits," which is like waving a red flag to a group of doctors. It would, for practical purposes, be indemnity insurance in which the patient pays nothing; everything would be covered by the plan. The physician would be pleased with the situation, and you know the patient would be; that is his idea of medical utopia. Furthermore, the doctor would be satisfied because he would be getting a 100 per cent collection.

Let us compare this optimal situation with the practical functions of an existing Blue Shield service benefit or full payment program. There is only one difference, and again the consideration is money, the root of all evil. In the first instance, the physician set his own fee schedule. Under the Blue Shield Plan, it is arranged and accepted by himself and a large group of his fellow practicing physicians, rather than by himself alone. I rather feel that if you are not willing to accept a fee schedule that you and your fellow physicians have worked on, you just do not trust your fellow physicians.

It seems very definite that the only obstacle that the nonparticipating or reluctantly participating physician finds to supporting a full payment program is that in order to do so, he must relinquish his right to construct his own individual fee schedule for every professional service he renders. The nonparticipating physician is not willing to relinquish this right, even to his fellow physicians and to work with them to construct a schedule, although he has just as much influence as each of them has in the determination of dollar amounts of the Blue Shield full payment schedule.

I should like to digress just for one moment about the questionnaire sent to you. I have received some letters, as have other members of the Committee of Seventeen. Many replies are, "We're not going to let Blue Shield set our fees." Again we come back to something that has been said all day long and I hope we will take home with us. We are Blue Shield, and I would much rather have us, as Blue Shield, setting our fees than a commercial insurance company board. I do not know how many of you make insurance examinations, but for how many years have you been trying to get the physical examination fee for routine insurance examinations raised to a reasonable figure? In the 15 years that I can count in my own life as a practicing physician, we have received from $3 to $5, and if there were not competitive standards such as Blue Shield, we would be in the same fix in regard to the fees that commercial insurance companies set for us on their policies. It is an easy tendency to assume that any fixed fee is necessarily incorrect. This is far from the truth. One of the major reasons why the cost of physician service has not kept pace with the rising cost of living is because most physicians have adhered for many years to their own particular pattern of fees. These fees, of course, are fixed, but they are fixed by the physician himself and, therefore, we may presume that he feels they are correct.

Once again we return to the view that the correctness of a fixed fee depends on who does the fixing. Under the full payment Blue Shield service benefit plan, practicing physicians are the ones who fix fees for themselves. This is as it should be. The practicing physician has nothing

to say about the fees provided in commercial insurance contracts. If we eventually come to a governmentally controlled medical program, medical fees in keeping with familiar bureaucratic policy probably will be arrived at by the one person who can be found in the government who knows least about the practice of medicine, certainly not by the practicing physicians who will provide the professional services. Medical costs must not be all the traffic can bear, and I assure you as a member of our county screening committee that there is a vast difference in what a fee is when a patient is paying for it, and what it is when an insurance company is paying for it. We lose sight of the fact that any of us who have money in the bank are shareholders in an insurance company. The public already seems to be aware that, in some instances, indemnity insurance may represent a liability rather than an asset, when their physician comes to make out his bill.

I have tried to summarize in four axioms the present situation as far as the practicing physician is concerned.

1. If in the future the physician expects to be paid, insurance coverage is going to do it.
2. If insurance is to do it, medical fees must be stabilized.
3. If medical fees are to be stabilized, practicing physicians are to do it.
4. If practicing physicians are going to do it, each physician must surrender some of his individuality on behalf of the profession as a whole.

Condensation of Questions, Answers and Discussion

Dr. Herschel G. Cole, of Tampa, stated that he was the official spokesman for the delegation from the Hillsborough County Medical Association and was instructed to inform the group that his county society was opposed to an increase in the income level and further that it wished psychiatric treatment included. He also stated that the Florida Orthopedic Society was opposed to elevation of the income levels.

Dr. W. Dean Steward, of Orlando, asked the following questions: 1. Is there any provision to be made for an initial history and physical examination on patients? 2. Is there any provision to be made for more than one visit daily when it is indicated? 3. Will there be any coverage for the first two days? 4. Is there any provision to be made for consultation and for follow-up visits for those patients who are seen in consultation? 5. Will any provision be made toward paying the attending physician for his care for those patients who are admitted to the hospital with medical problems, or what are thought to be medical problems, and who in the course of their hospitalization require surgery?

Dr. Robert E. Zellner, of Orlando, made the following remarks in reference to Dr. Cole's statement as well as Dr. Steward's questions: First of all, the entire problem is not to increase service benefits but to increase fees. The problem right now is that the fee schedule is entirely inequitable. There needs to be a complete revision. There are some fees in there, few though they are, that are ridiculously high. The problem is to get more equitable fees. How are we to do it? It may be that raising the service income limits to some extent may be part of it, in order to increase the participation and in order to make it more of a bargain.

I do not think we are competent to answer Dr. Steward's questions. We are a fact-finding committee. First of all, we are to get facts about and from Blue Shield to bring to you. Secondly, we are to get facts from you to take back to Blue Shield as to what you will accept. I am convinced that the membership of the committee agrees entirely with Dr. Steward's thinking and that this contract must cover medical services and it must cover them more adequately. It is interesting to point out that this problem in a commercial company would not even come up. Commercial companies do not care whether you have had a consultation or not. They pay so much for an operation or for so many days in the hospital, and if you have three or four doctors, that is your problem. So that again reinforces the fact that Blue Shield is the doctors' plan, and it is something that cares about your opinion. I am convinced that if we do not do something to improve the attractiveness of this contract, we are not going to have the money to apportion it. These are certainly valid questions, and as far as I am concerned, this committee is in sympathy with the solution of them in the manner indicated by each question itself. All of this is contingent upon the Blue Shield actuary, but our sympathy is with the inclusion of adequate payment for medical service.

Dr. Steward.—When we say the commercial company is not interested in consultation or anything else, neither is the commercial company interested in whether we are paid. That is between us and our patients. The commercial companies cannot tell a patient that his policy covers everything, and this brings up something we must remember when we talk Blue Shield. Blue Shield says to the buyer, "Here's a service policy rendered by the doctor, and he shouldn't charge any more than is covered," but the commercial company cannot do that. Are we forgetting that Blue Shield deals with us and, therefore, should consider us, instead of the patient alone or the amount of finances in the company alone?

Dr. Donald F. Marion, Miami.—In regard to Dr. Steward's questions, I wish I knew the answers. I feel that there is a great deal implied by any service contract. Such contracts imply that all the patient has to do is select a good doctor and have a diagnosis made automatically. All he has to do is say, "I'm now your patient," and all the doctor has to say is, "Okay, I'm now your doctor, and I know what's wrong with you." That is exactly how ridiculous it is. People say they would like to have diagnostic care. Everyone says we cannot afford diagnostic care. We can afford to operate on you, but we cannot afford to find out what is wrong with you.

There is no incentive at the present time to take advantage of the better diagnostic means that are available because of this penny-pinching economic mess that everybody is in. Now that is something we must do something about.

Dr. Cole.—We want to maintain the form for the indigent, the present status quo in so far as income limits are concerned. We do not want to go into the higher income levels, because we feel that when we do, we are socializing ourselves.

Dr. Henry J. Babers Jr., Gainesville.—I think it is clear that in all medical work we define our terms. When you say we are socializing ourselves, you have to know what socialization is. Socialism is an economic system in which the production of capital goods is controlled by the government, not by Blue Shield. I believe you mean trade unionism instead of socialism, any union or group, a syndicalism you might call it. This is entirely different from socialism.

Dr. Edward R. Annis, Miami.—Two years ago, we had 16 million people in this country over 65 years of age; today, we have 18.5 million. There is no provision in the commercial companies to take care of these people, the retirees and the indigent. If we do not provide for them and the commercial companies will not do it, there is no one else to do it but the government, which certainly will do it. If we were right in the first place to support Blue Shield as a defense against the onward march of socialism, then we must still be right in supporting the principle. If it cannot stand on its own two feet by selling only to the indigent, then the only way we can finance it actuarily is to invade the general community. As one from a larger community, however. I agree with those speakers who have said that if we maintain the status quo, we are going out of business. I know of various corporations in Miami at the present time that are negotiating new health contracts, and Blue Shield is being pushed out of the picture because we cannot compete with what is being offered by some of these plans, major medical plans and others. What do you think the answer is? Are we going to satisfy the demands of the various branches of the profession who should be justly treated by equally distributing the funds? By the same token, if we are going to continue to sell Blue Shield, we are going to have to increase our coverage over a wider area, in order to compete with commercial companies which are offering these major medical and other benefits. What do you propose? I know the Dade County Public Schools and a few other major users and subscribers to Blue Shield are going to fall by the wayside in the next year or two if we do not do something about it. What is your idea as to where we should go and what we should be thinking about when we go back home and try to carry this wealth of information to others who have been equally muddled in their thinking concerning Blue Shield and its problems?

Dr. H. Phillip Hampton, Tampa.—I should like to ask if we have any information or experience to go on to consider the advisability of issuing an additional Blue Shield major medical deductible policy to go along with the basic plan that is now available, in preference to increasing service benefits on an income level basis.

Dr. Gretchen V. Squires, Pensacola.—Instead of answering that question, I am going to give you a question of my own. The income level of $3,600 ten years ago is now approximately $4,900, or very close to $5,000. Let us go back to the

Hillsborough question of status quo. To maintain the status quo, we have to start out at approximately the $5,000 level instead of the $3,600 level. That is the first point. How many of you would be any worse off financially if you received 100 per cent collection on all your patients whose income was $5,000 or less, than you are at the present time not collecting from the patients who are uninsured because they would not buy indemnity benefits and are not eligible for service benefits? I was interested in checking over some of the answers of the questionnaire as to how few doctors put down a different fee for a person in the $5,000 income bracket as against the $7,500 income bracket. I think most of us work on a standard fee. Is not 100 per cent collection of a fixed fee from 85 per cent of the population, when that fee has been fixed by you and is adequate, better than a large segment of the population not paying its bills, or you reducing them voluntarily because you know this group cannot afford to pay them?

Dr. Babers.—As far as unity and organization are concerned, I will follow what anybody says, as long as it is a majority. The main trouble, however, is that the way this is set up, Blue Shield cannot move in any way whatever. Blue Shield cannot change a thing because it has to have our permission before it can do it. So when you say major medical and all what not, the first premise is that until someone tells Blue Shield it can at least start working on it nothing happens. As for what our committee would recommend, we plan to get together perhaps in February and come up with our own recommendations.

Dr. Marion.—I should like to discuss Dr. Hampton's question about a separate medical policy. This committee talked about a major medical rider to be attached to the regular plan. Every place it has been tried, it has been virtually unsalable. If we are to survive, we are obliged to sell something the people want.

Dr. Frederick H. Good, Denver.—We, in Colorado, have a major medical coverage set up that started out originally in district nine. We have sold it to several groups and are now watching it. We also sold to these groups a home and office call rider, by demand, and we are watching that with considerable interest. The interesting thing is, if you have an adequate service income limit, and if you have a realistic fee schedule that the doctors can live with, you are not going to have much demand for this so-called prolonged illness coverage, except in the areas where pressure is on. You will sell that to the executive class. Labor is now demanding the employer put money in the kitty to provide this coverage, but is not particularly interested in this so-called prolonged illness coverage, although it is cheap.

In regard to the old people in Colorado, we just signed a contract with the State Welfare Department to take over the old age pensioners and we are doing that on a cost plus basis on a six months' trial. We are doing it on our old standard contract, which is our $2,400 service income limit contract. The old age pensioners get between $80 and $100 per month; starting in February, there will be enough money available in the state to start this plan. These old age pensioners are a problem. We are going to try this for them because it was either that, or, as we were frankly told, closed panel. We were simply told that the money was available and the Department was going to buy the care and were asked whether or not we were interested.

Dr. Babers then thanked the members for their attendance and participation and closed the meeting with the thought that each person in attendance should carry back to his society as much information as possible.

OTHERS ARE SAYING

Editorial

The Public Wants to Know

The lay public has shown an increasing interest and demand for medical information. Most large circulation magazines carry a medical column that apparently is widely read. The local response to the recent telecast of a heart operation shows how the public is interested in their own health.

Many times the average individual becomes confused by what he or she reads and is the source of poor advice to their friends. The readers are frequently misled by sensational articles written to improve the author's financial state rather than to provide useful information. Frequently experimental medicines or methods are reported as proven and accepted facts. These are all drawbacks to the dissemination of information to the lay public.

The public is no longer satisfied with the simple admonition "take these pills and every-

thing will be O.K." or "you need an operation." They demand explanations and this frequently takes more time than the actual treatment of the patient. Even the most painstaking explanations are twisted and confused by apparently intelligent persons.

One way to improve the education of the lay public and to satisfy their demand is in the use of Medical Forums. Here is a place where we can meet the public, create goodwill for our medical association and profession, and expose quack methods and beliefs. The first such Forum was held recently and was quite successful. Over 700 persons attended and if the pattern is followed here as in other cities the audience should increase in size with subsequent programs. The participants are to be congratulated for their efforts and preparation.

Eventually all members of our Association who desire to participate will be called upon to serve upon the panel. Tentative plans are to hold two or three more Forums this winter with the next one scheduled for January 16th. The Fort Lauderdale Recreation Department and the Fort Lauderdale Daily News are giving us their full cooperation in these Forums and it behooves us to give our fullest measure of help as we are all directly benefited. The lay public wants to know and will find out — let's make it correct information and not misconception.

Richard L. Foster, M.D.
The Record, Broward County Medical Association
December, 1957

STATE NEWS ITEMS

Dr. Theodore F. Hahn Jr. of Deland attended the recent six day course in cardiology held at the Grady Hospital in Atlanta.

Dr. Chas. J. Collins of Orlando attended the meeting of the South Atlantic Association of Obstetricians and Gynecologists held at Hollywood.

Dr. J. Harold Newman of Jacksonville presented a paper entitled "Nephro-Ureterectomy" at the meeting of the Southeastern Section of the American Urological Association held recently at Hollywood.

Dr. Thomas J. Bixler of Tallahassee has accepted appointment to the Committee for the employment of the Handicapped recently organized by Governor Leroy Collins.

Dr. David Sloane of Lakeland recently addressed the Woman's Club there on the subject "My Aching Back." The more usual types of backaches were explained and the treatment described. Considerable attention was given to prolotherapy injections for chronic relaxation of the ligaments of the lower back. The address was sponsored by the Education Department of the Woman's Club.

Dr. Alfred G. Levin of Miami has been elected president of the Greater Miami Radiological Society. Serving with Dr. Levin are Dr. Andre S. Capi of Hollywood as vice president and Dr. George P. Daurelle of Miami as secretary-treasurer.

Dr. Frank W. Putnam of Gainesville, Professor of Biochemistry at the College of Medicine, University of Florida, has been appointed to the Divisional Committee for Biological and Medical Sciences of the National Science Foundation.

The Second Annual Seminar on Cardiovascular Disease sponsored by the Hillsborough County Heart Association was held March 29 in Tampa. Dr. Richard G. Conner of Tampa served as program chairman. Speakers included Dr. Jack Myers, Chairman, Department of Medicine, University of Pittsburgh School of Medicine, Dr. Denton A. Cooley, Associate Professor of Surgery, Baylor University College of Medicine, Dr. Samuel Kaplin, Children's Hospital, Cincinnati, and Dr. Herman K. Hellerstein, Assistant Professor of Medicine, Western Reserve University School of Medicine.

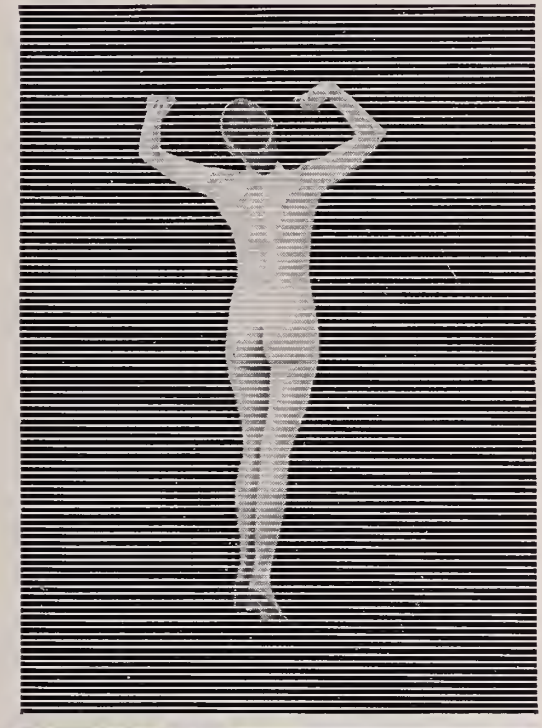
The Eleventh Annual Convention of the Florida Society of Medical Technologists has been scheduled for May 23-25 in Clearwater at the Ft. Harrison Hotel.

The Florida Trudeau Society will hold its annual meeting April 25-26 at the Ft. Harrison Hotel in Clearwater, according to announcement by Dr. Howard M. DuBose of Lakeland, president. Dr. William R. Barclay, Associate Professor

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of Medicine, School of Medicine, University of Chicago, will be keynote speaker. Dr. Kip G. Kelso of Vero Beach is chairman of the program committee.

Dr. Albert V. Hardy of Jacksonville is serving on the committee appointed by the Nuclear Development Commission to draft a program to encourage maximum development and utilization of atomic energy in Florida consistent with protection of the public against possible radiological hazard.

Drs. Joseph J. Ruskin of Tampa and Lucien Y. Dyrenforth of Jacksonville served on the Committee on Arrangements for the annual meeting of the Atlantic Coast Line Railroad Surgeons' Association held March 21-24 at Nassau with headquarters on the S. S. Florida. Dr. Richard A. Worsham of Jacksonville discussed "Knee Injuries" at the scientific session on March 22, and Dr. Dyrenforth presided during the business session held the following day.

Dr. Paul S. Jarrett of Miami has been appointed by Governor LeRoy Collins to the Advisory Council, Alcoholic Rehabilitation Program.

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The Fifth International Congress of Internal Medicine has been scheduled for April 24-26 in Philadelphia with headquarters in the Sheraton Hotel. Following the Congress, the Annual Session of the American College of Physicians is being held at Atlantic City April 28-May 2.

Dr. W. Lawson Shackelford of West Palm Beach, president of the Palm Beach County Medical Society, has received a letter from the County Commission in which official appreciation was expressed to members of the Society for their time and effort expended in providing medical treatment for indigent sick persons within the county.

Dr. Leonard G. Rowntree of Miami Beach has been awarded the honorary Doctor of Letters degree by the University of Miami for "his great contributions to the progress of medicine and his significant role in the founding of the University of Miami School of Medicine."

Dr. Photis J. Nichols of Apalachicola was principal speaker at a recent meeting of the Philaco Club of that city. His subject was cancer.

Dr. Karl R. Rolls of Sarasota was the initial speaker for the Vocational Guidance Clinic held in that city for the benefit of high school students. Dr. Rolls is president of the Sarasota County Medical Society.

Dr. Eunice M. Lache of Tampa is serving as instructor for the class in medical terminology being sponsored at the University of Tampa by the Medical Secretaries and Assistants Association.

Dr. James H. Ferguson of Miami, Chairman of Obstetrics-Gynecology Department at the Uni-

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versity of Miami School of Medicine, presented a paper at the Twentieth Annual Meeting of the South Atlantic Association of Obstetricians and Gynecologists held recently at Hollywood.

Dr. S. Carnes Harvard of Brooksville is serving as medical chairman for the 1958 Heart Fund Drive in Hernando County.

Dr. Richard A. Henry of Brooksville has been designated "Outstanding Young Man of the Year" by the Junior Chamber of Commerce of that city. He is a former president of the Rotary Club, a member of the Junior Chamber of Commerce, and is active in Boy Scout activities.

Dr. William C. Roberts of Panama City, President of the Florida Medical Association, and Drs. Walter C. Payne Sr. and Herbert L. Bryans of Pensacola, both Past Presidents of the Association, will serve as fraternal delegates to the annual meeting of the Medical Association of the State of Alabama being held April 17-19 at Montgomery.

A Symposium on the Management of Cardiovascular Problems of the Aged is being held Saturday, April 12, in the Eden Roc Hotel at Miami Beach. It is sponsored by the Dade County Medical Association. Co-sponsor is the J. B. Roerig Company.

Dr. Chas. J. Collins of Orlando has been reelected president of the Florida State Board of Health.

A Medico-Legal Institute sponsored by the Florida Medical Association and the Florida Bar is being held in Tampa April 11-12. Physicians from Florida appearing on the program include Drs. John E. Gottsch, and Frank H. Lindeman Jr. of Tampa, and Drs. Ben J. Sheppard, W. Tracy Haverfield and Herbert Eichert of Miami.

Dr. William C. Roberts of Panama City, President of the Florida Medical Association, will be in Gatlinburg, Tenn., April 21-23, for the annual meeting of the Tennessee State Medical Association being held there.

The First Annual Postgraduate Seminar in Pediatrics will be conducted by the combined faculties of the Georgetown and George Washington Departments of Pediatrics at the Children's Hospital of Washington, D. C., May 22-24. Application blanks may be obtained from the Director of Medical Education, Children's Hospital of Washington, D. C., 2125 Thirteenth Street, N.W., Washington 9, D. C.

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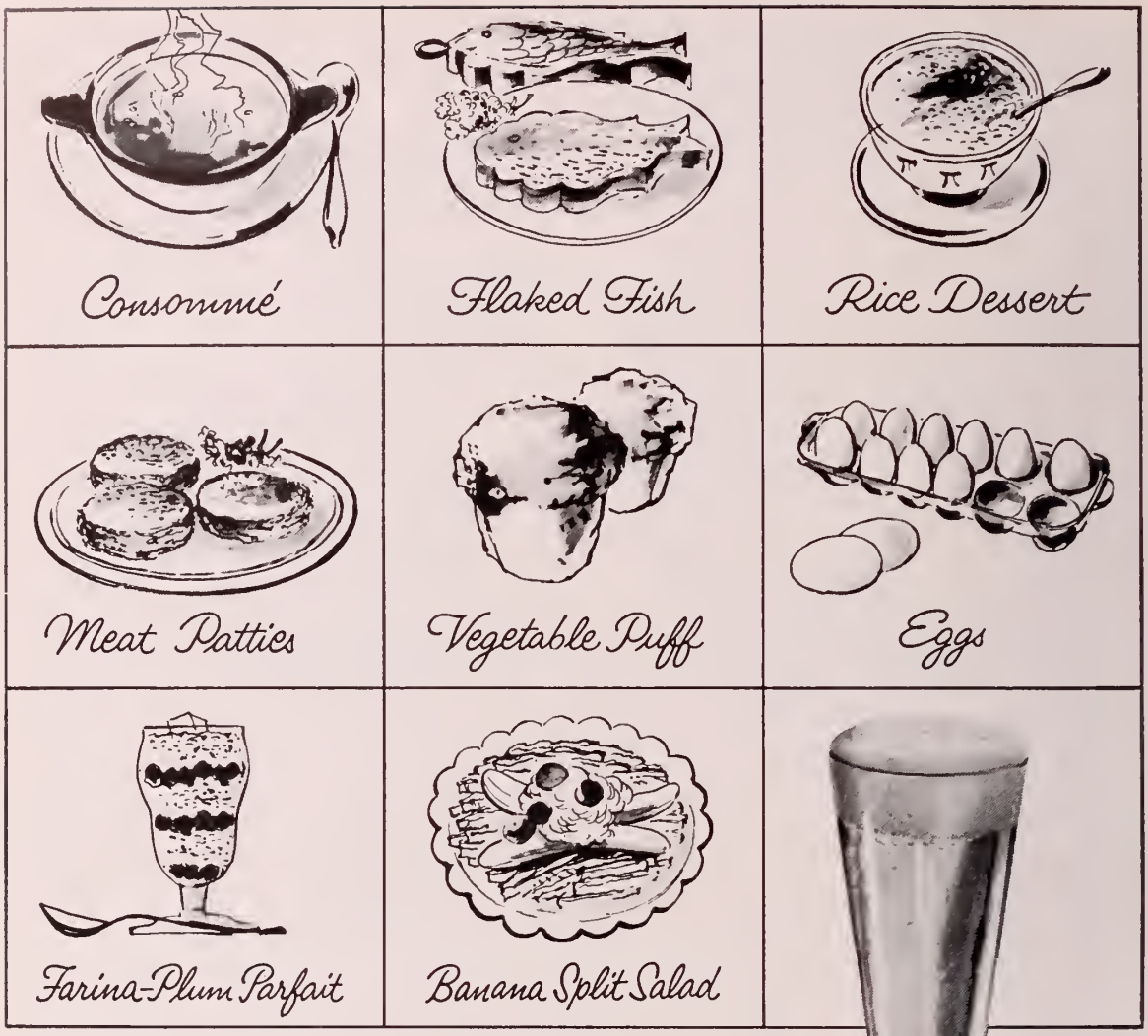
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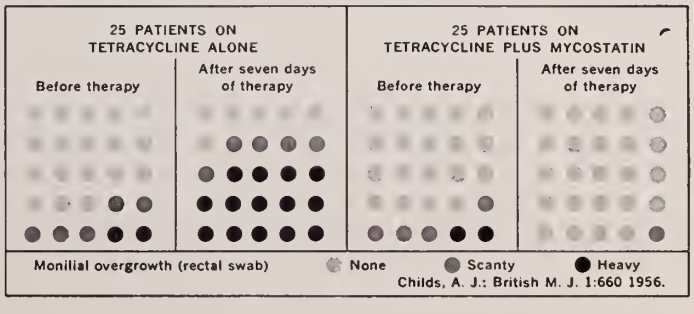
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COMPONENT SOCIETY NOTES

Alachua

Dr. William C. Roberts, of Panama City, President of the Florida Medical Association, was principal speaker for the March meeting of the Alachua County Medical Society.

Brevard

Dr. John M. Langstaff, of Melbourne, and Dr. Robert G. Rosser, of Cocoa, were scientific speakers for the February meeting of the Brevard County Medical Society. Dr. Langstaff presented a comprehensive address on renal calculi and the theories of formation, and Dr. Rosser discussed methods of removal, emphasizing the multiple ureteral catheter technic. Films and specimens from several interesting cases were shown.

Collier

The Collier County Medical Society has paid 100 per cent of its state dues for 1958.

Dade

"Can We Have a Safe Social Security?" was the topic for discussion at the March meeting of the Dade County Medical Association. Film slides were shown by Mr. W. W. Edwards, executive secretary of the Miami Association of Life Underwriters.

Duval

The March meeting of the Duval County Medical Society was held at the U. S. Naval Air Station Hospital. Speakers included Cmdr. D. A. Doohen, MC, USN, who discussed "Superior Arterio-Mesenteric Obstruction of the Duodenum;" Lt. Cmdr. Mason Romaine III, MC, USNR, "Dissecting Aneurysm in Youth," and Lt. E. G. Sheehan, MC, USNR, "Postpartum Hemorrhage, A Case Report."

The Society has paid 100 per cent of its state dues for 1958.

Indian River

The Indian River County Medical Society has paid 100 per cent of its state dues for 1958.

Jackson-Calhoun

The Jackson-Calhoun County Medical Society has paid 100 per cent of its state dues for 1958.

(Continued on page 1160)



* J.A.M.A. *166*:158,1958; Welsh, A.L. and Ede, M. *"...prompt remissions of...acute phases."* with TARCORTIN

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* 1. Clyman, S. G.: Postgrad. Med. *21*:309, 1957.
2. Bleiberg, J.: J. M. Soc. New Jersey *53*:37, 1956.
3. Abrams, B. P., and Shaw, C.: Clin. Med. *3*:839, 1956.
4. Welsh, A. L., and Ede, M.: Ohio State M. J. *50*:837, 1954.
5. Bleiberg, J.: Am. Practitioner *8*:1404, 1957.



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References: 1. Groskloss, H. H., et al: Clin. Med. 2:885 (Sept.) 1955. 2. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957.

(Continued from page 1156)

Lake

Dr. Leroy H. Oetjen, of Leesburg, presented the program for the February meeting of the Lake County Medical Society which was held at Leesburg. Dr. Oetjen discussed his recent trip to Washington, D. C., where he met with Congressional representatives and members of the A.M.A. staff to discuss impending legislation, particularly the Forand bill and the Herlong-Keough bill.

The Society has paid 100 per cent of its state dues for 1958.

Madison

The Madison County Medical Society has paid 100 per cent of its state dues for 1958.

Manatee

The Manatee County Medical Society has paid 100 per cent of its state dues for 1958.

Marion

The Marion County Medical Society has paid 100 per cent of its state dues for 1958.

Monroe

The Monroe County Medical Society has paid 100 per cent of its state dues for 1958.

Pinellas

Dr. Irwin S. Leinbach, of St Petersburg, was principal speaker for the March meeting of the Pinellas County Medical Society. The title of his address was "Doctor Defendant; His influence on Patient Relationship."

Taylor

The Taylor County Medical Society has paid 100 per cent of its state dues for 1958.

Medical Officers Returned

Dr. Mason Romaine III, who entered military service on March 31, 1956, was released from active duty on December 31, 1957, with the rank of lieutenant commander, U. S. Navy. His address is 1661 Riverside Ave., Jacksonville, Fla.

Dr. William Stromberg, who entered military service on July 8, 1955, was released from active duty on July 4, 1957, with the rank of captain, U. S. Coast Guard. His address is 432 Marshall Taylor Doctors Bldg., Jacksonville, Fla.

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NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Ayres, Thomas W., Daytona Beach
Barrineau, Charles E., Palatka
Beychok, Irving A., Sarasota
Boyd, Eugene J., Sarasota
Cook, Thomas D., New Smyrna Beach
Cooper, Leonard S., Sarasota
Crews, Frederick F., Fort Walton Beach
Crotzer, Malcolm C., Fort Walton Beach
Damsey, Lloyd, Marathon Shores
Dickerson, Edzell P., Bradenton
Ezzo, Joseph A., St. Petersburg
Foxworthy, Donald L., Tampa
Fritz, George S., Boca Grande
Graf, George P., Winter Haven
Greenwood, Robert W., Sarasota
Hodnett, James D., Pensacola
Howard, Woods A., Lakeland
Lambert, Walter R., Key West
Lawrence, Joseph W., Fort Myers
Lehman, John D., Sarasota
Liberman, Milton J., Sarasota
Lindsey, Edwin L., Sanford
Logan, John B., Sarasota
Marrero, Emilio J., Jay
Miles, George G., Orlando
Nichols, Thomas H., Clermont
Nickau, Robert H., Lakeland
Palmer, David B., Venice
Pfaff, Robert J., Lakeland
Ratchford, Lawrence A., Tampa
Robinson, James L. Jr., Naples
Robinson, Melvin S., St. Petersburg
Rye, William A., Brewster
Schanze, John K., Sarasota
Shively, John A., Bradenton
Smith, Ernest C. Jr., Englewood
Uthlaut, William W., Winter Garden
Watkins, Lee C. Jr., Clearwater
Williams, Thomas C. Jr., Crestview
Zeller, Frank Jr., Winter Haven

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ENCES:
herbel, A. L., Schuchter, S. L., and Harrison, J. W.: *Cleveland Clin. Quart.* 24:98, Apr., 1957.
hoch, A. G., and Alexander, L. J.: The Schoch Section, *Bull. A. M. A. Dermatologists* 2:29, Nov., 1955.
nbleet, Theodore: Arch. Dermat. 73:572, June, 1956.

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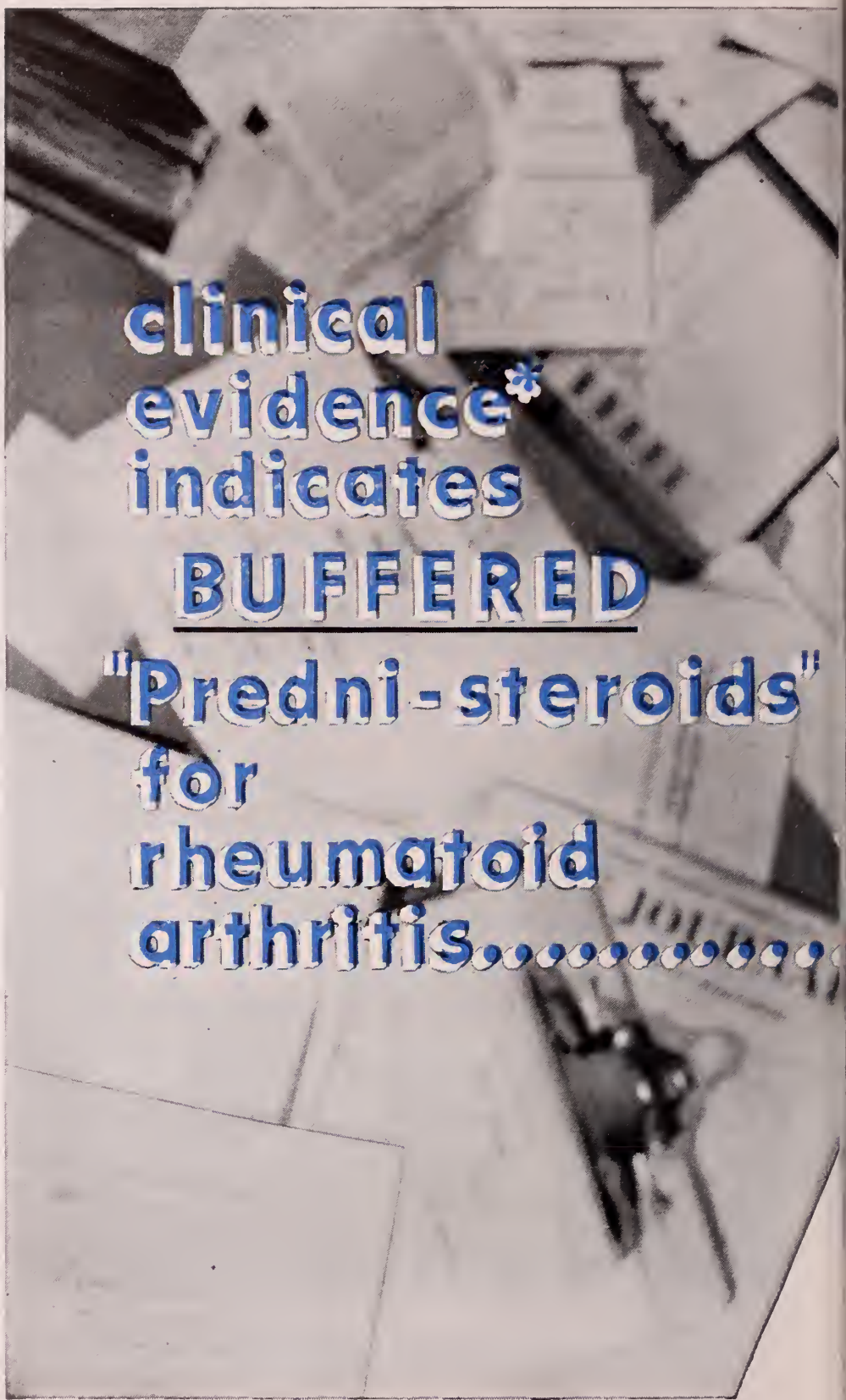
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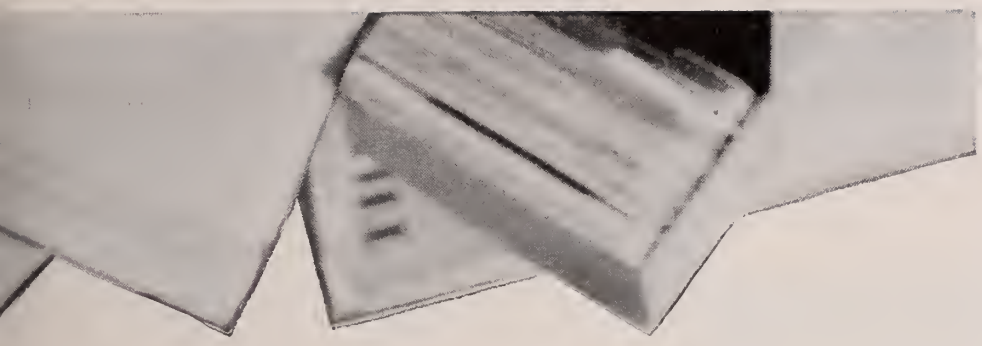


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offset any gastrointestinal
ts."—Dordiek, J. R. *et al.*:
te J. Med. 57:2049 (June
.

*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine co-administration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:459 (June 11) 1955.

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OBITUARIES

Texas Alexander Adams

Dr. Texas Alexander Adams of Daytona Beach died at Halifax District Hospital on Oct. 3, 1957. He was 81 years of age.

Dr. Adams, prominent Negro physician and civic leader, had practiced medicine in Daytona Beach for 51 years and had previously practiced for a short time in Key West. A native Floridian, he was born in Lake City on Sept. 10, 1876. He was a graduate of Cookman College in Jacksonville, which was later merged with Daytona Normal School to form Bethune-Cookman College in Daytona Beach. His medical training was received at Meharry Medical College in Nashville, Tenn., where he was awarded the degree of Doctor of Medicine in 1905.

For more than 40 years Dr. Adams was a member of the Board of Trustees of Bethune-Cookman College and in 1955 was selected a Father of the College in recognition of his work. He was medical director for the college and in charge of the college hospital for more than 15 years. The infirmary at the college is named for him.

In 1954 Dr. Adams became the second Negro to be appointed to the City Planning Board and recently he received a key to the city and a citation for his work with the board. He was an honorary member of the Medical Staff of Halifax District Hospital, and a member of the Elks Club, Knights of Pythias and Alpha Phi Alpha fraternity. For many years he was a trustee and a member of the official board of Stewart Memorial Methodist Church, and served as a delegate to many Methodist conferences.

Dr. Adams was a member of the Volusia County Medical Society. Since 1951 he had held membership in the Florida Medical Association and was also a member of the American Medical Association, the National Medical Association and the Dental and Pharmaceutical Association.

Survivors include three daughters, Mrs. John L. Slack, of Daytona Beach, Mrs. Preston S. Peterson, of Jacksonville, and Mrs. Sebron Willis, of Miami; a brother, Millard Adams, of Daytona Beach; a sister, Mrs. Darnell Watson, of Daytona Beach; a granddaughter, Mrs. Carrell Horton and a great grandson, Richard Horton, both of Nashville; and three nieces, Mrs. Ernestine Butler

(Continued on page 1172)

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[1] Nichols, R. L. and Finland, M.: J. Clin. Med. 49:410, 1957.

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1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954



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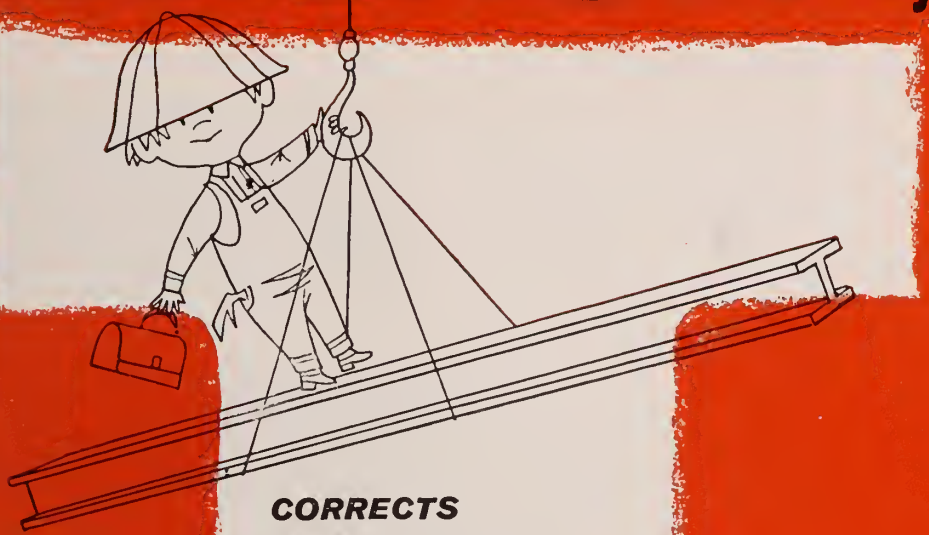
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(Continued from page 1167)

and Mrs. Thelma Young, both of Daytona Beach, and Mrs. Gwendolyn Watson, of New York.

Robert Gleve Neill

Dr. Robert Gleve Neill of Orlando died at Orange Memorial Hospital in that city on Oct. 19, 1957. He was 45 years of age. Interment took place in Greenwood Cemetery in Eustis.

A native of McKittrick, Calif., where he was born on July 2, 1912, Dr. Neill received his academic training at the University of California. He was awarded both the Bachelor of Arts and the Master of Science degrees by that institution. For his medical training he turned to Duke University School of Medicine and was graduated with the degree of Doctor of Medicine in 1940. His special training in neurosurgery and neuropathology was also received there.

Entering the Medical Corps of the United States Army in 1945 with the rank of captain, he was appointed Chief of an Army Mobile Neurosurgical Unit. He saw much action both in Okinnawa and in Korea and was discharged with the rank of major.

Upon his release from military service, Dr. Neill entered the private practice of neurological surgery in Orlando on July 1, 1949. At that time he was the fourth neurosurgeon in the entire state. He was on the staffs of Orange Memorial Hospital, Florida Sanitarium & Hospital, Winter Park Memorial Hospital, Holiday House and Central Florida Tuberculosis Hospital, and was a consultant to Orlando Air Force Base Hospital. He was associated in practice with Dr. J. Cornall Howarth.

A member of the Orange County Medical Society, Dr. Neill was also a member of the Florida Medical Association, the American Medical Association and the World Medical Association. In addition, he held membership in the Southern Neurosurgical Society and the Congress of Neurological Surgeons.

Dr. Neill is survived by his widow, Mrs. Lois Neill, a son, Darryl Neill, and two daughters, Diantha and Debra Neill, of Orlando.

Frank Oliver Nichols

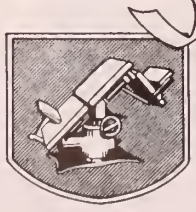
Dr. Frank Oliver Nichols of Miami died of a heart attack in his home on Dec. 5, 1957. He was

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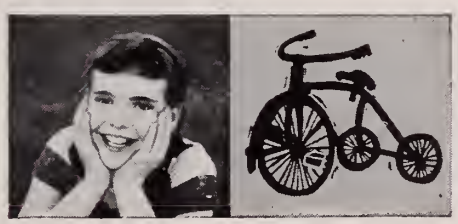
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59 years of age. Interment was in Etowah, Tenn.

Born in Warne, N. C., on Feb. 13, 1898, Dr. Nichols was educated in Tennessee. After receiving his academic education at the University of Tennessee in Knoxville, he entered Vanderbilt University School of Medicine in Nashville and was awarded the degree of Doctor of Medicine in 1920. He served in the Navy Medical Corps in World War I and was a major in the Army Medical Corps in World War II.

In 1945, Dr. Nichols came to Miami from Knoxville and had since that time engaged in the general practice of medicine there. He was a member of the Baptist Church.

Dr. Nichols was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He was also affiliated with the American Academy of General Practice.

His widow, Mrs. Mabeth D. Nichols, survives him. Other survivors are a son, 1st Lt. Frank O. Nichols Jr., of Pine Castle Air Force Base; his mother, Mrs. Flossie Nichols, and a sister, Mrs. D. H. Meredith, both of Pulaski, Va.

John Turner McDermid

Dr. John Turner McDermid of Fort Pierce died on Nov. 22, 1957, after an illness of several months. He was 46 years of age.

A native of Sparks, Ga., Dr. McDermid moved to Florida with his family in 1929, residing in Okeechobee. He was graduated from the high school there. Before studying medicine, he was superintendent of a wholesale grocery chain in Georgia for 12 years. He received his medical training at the University of Georgia and was awarded the degree of Doctor of Medicine by the Medical College of Georgia at Augusta in 1948. Following graduation, he served an internship at the Baroness Erlanger Hospital in Chattanooga, Tenn.

In 1949, he entered the private practice of medicine in Fort Pierce and continued to practice there for eight years. Locally, he was on the staff of the Fort Pierce Memorial Hospital and was a member of the First Baptist Church.

Dr. McDermid was a member of the St. Lucie-Okeechobee-Martin County Medical Society. Since 1950, he had held membership in the Florida Medical Association and he was also a member of the American Medical Association.

(Continued on page 1175)



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(Continued from page 1174)

Surviving are the widow, Mrs. Mariam McDermid, a son, John Jr., and a daughter, Marcia Sue, all of Fort Pierce. Other survivors include his mother, Mrs. H. C. McDermid of Vidalia, Ga.; a brother, Dr. Howard C. McDermid of Fort Pierce; and two sisters, Mrs. Burnett Bartlett of Okeechobee, and Mrs. H. S. Musgrove of Homerville, Ga.

Warren Ainsworth Brooks

Dr. Warren Ainsworth Brooks of Winter Park died in a local hospital on Nov. 9, 1957. He was 42 years of age.

The son of a Methodist minister, Dr. Brooks was born on Feb. 23, 1915 in Adel, Ga., and during his childhood lived chiefly in South Georgia. He received his academic training at Emory University, where he was awarded the degree of Bachelor of Science in 1934. He pursued his medical training at his alma mater, receiving the Doctor of Medicine degree from the School of Medicine in 1938. He then interned at Orange Memorial Hospital, known at that time as Orange General Hospital, in Orlando. His medical fraternity was Alpha Kappa Kappa and his social fraternity Alpha Tau Omega.

In July 1939, Dr. Brooks entered the general practice of medicine in Orlando, but both his further postgraduate study and his practice were interrupted by repeated bouts of tuberculosis. His devotion to his profession placed him again in private practice in 1954 when he became associated with Dr. Ruth Jewett in Winter Park. Locally, he was on the staffs of Orange Memorial Hospital, Winter Park Memorial Hospital and Florida Sanitarium and Hospital. He also served on the staff of the Central Florida Tuberculosis Hospital for five years. He was a member of Masonic Lodge 69 and of the Winter Park Lions Club.

Dr. Brooks was a member of the Orange County Medical Society, the Florida Medical Association and the American Medical Association. He also held membership in the Trudeau Society and was a fellow of the American College of Chest Physicians.

Surviving are the widow, Mrs. Julia A. Brooks, and his parents, the Rev. and Mrs. J. C. G. Brooks, of Winter Park; two brothers, Julian W. Brooks, of Panama City, and William G. Brooks, of Savannah, Ga.; and a sister, Mrs. R. D. Pulliam, of Decatur, Ga.



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Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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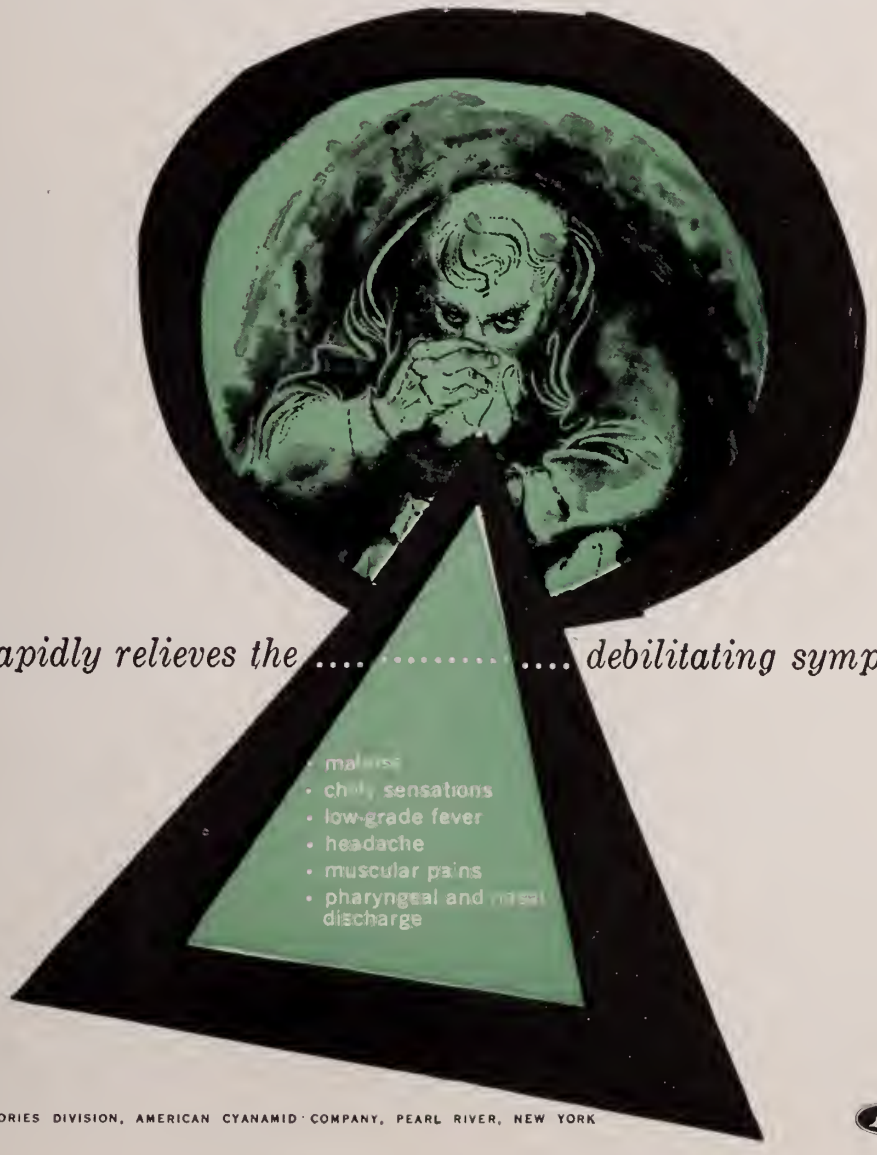
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BOOKS RECEIVED

Clinical Toxicology of Commercial Products. Acute Poisoning (Home & Farm). By Marion N. Gleason, Robert E. Gosselin, M.D., Ph.D., and Harold C. Hodge, Ph.D., D.Sc. Pp. 1160. Price, $16.00. Baltimore, The Williams & Wilkins Co., 1957.

This unique and invaluable book contains a startling amount of toxocologic information never before in print or under one cover. It is intensely practical and is arranged for speedy, emergency use. As stated in the Foreword, this reference volume, designed to make urgently needed information immediately available, should be most helpful to any physician faced with a patient who has swallowed some possibly toxic trademarked product. Pediatricians and general practitioners will find it especially useful. Medical libraries, pharmacies, industrial medical departments, public health nursing centers, and any agency frequently called upon for emergency help should also find it helpful as a quick source of information on first aid, treatment procedures, and other questions. Widespread and immediate use of such a reference can help to prevent deaths from chemical poisoning.

The book provides (a) a list of trade name products together with their ingredients when these have been available, (b) sample formulas of many types of products with an estimate of the toxicity of each formula, (c) toxocologic information including an estimate of the toxicity of individual ingredients, (d) recommendations for treatment, and (e) names and addresses of manufacturers. The price includes a free supplement to be issued next year.

Modern Perinatal Care. By Leslie V. Dill, M.D., F.A.C.S. Pp. 309. Price, $6.50. New York, Appleton-Century-Crofts, Inc., 1957.

The purpose of this text is to present, briefly and concisely, a digest of informed current thought and offer modern technics for the total care of women from earliest pregnancy through labor and the postpartum period. All available source material has been utilized and tempered by the experience of the author and 16 valued consultants to define the physiologic limits for normal pregnancy, clarify present trends in prophylaxis and therapy for the normal gravida and present effective methods and therapies for treating the various pathologic conditions which may occur during pregnancy and complicate it. Many of the methods included are designed for use by physicians without access to elaborate hospital facilities and which can be safely depended upon in emergencies or until specialty consultation service is available.

Among the obstetric problems discussed are abortion, pelvic mensuration, toxemias and anemias of pregnancy, the fourth stage of labor, and the complications to pregnancy arising from such conditions as heart disease, diabetes mellitus, thyroid disorders, tuberculosis, and venereal diseases. Attention is given to nutrition in pregnancy and to the psychologic aspects of pregnancy. Various problems relative to the infant are also considered: fetal mortality, birth injuries, congenital malformations, and infant feeding. The two concluding chapters cover the medicolegal, and religious problems encountered in obstetric practice.

Manual of Nutrition. Pp. 70. Price, $3.50. New York, Philosophical Library, 1957.

This book presents concisely and simply the principles of nutrition, not only to teachers and students of home

(Continued on page 1186)

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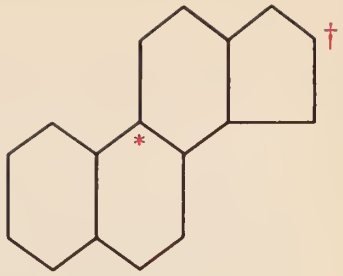
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- **a new high** in anti-inflammatory effects with lower dosage (averages 1/3 less than prednisone)
- **a new low** in the collateral hormonal effects associated with all previous corticosteroids
 - No sodium or water retention
 - No potassium loss
 - No interference with psychic equilibrium
 - Low incidence of peptic ulcer and osteoporosis

Biological Effects of Aristocort

with particular emphasis on:

Kidney function

Animal studies on ARISTOCORT[1] have not demonstrated any interference with creatinine or urea clearance. Autopsy surveys of organs of animals on prolonged study of this medication have shown no renal damage.

Sodium and water

ARISTOCORT produced an increase of 230 per cent of water diuresis and 145 per cent sodium excretion when compared to control animals.[1] Metabolic balance studies in man revealed an average negative sodium balance of 0.8 Gm. per day throughout a 12-day period on a dosage of 30 mg. per day.[2] Additional balance studies showed actual sodium loss when ARISTOCORT was given in doses of 12 mg. daily.[3] Other investigators observed significant losses of sodium and water during balance studies and that those patients with edema from some older corticosteroids lost it when transferred to ARISTOCORT.[4,5] In two studies of various rheumatic disorders (194 cases) on prolonged treatment, sodium and water retention was not observed in a single case.[6,7]

Potassium and chlorides

There was no active excretion of potassium or chloride ions in animals given maintenance doses of ARISTOCORT 25 times that found to be clinically effective.[1] Potassium balance studies in humans[2,3] revealed that negative balance did not occur even with doses somewhat higher than those employed for prolonged therapy in rheumatoid arthritis. Hypokalemia, hyperkalemia or hypochloremia did not occur, when tested, in 194 patients with rheumatoid arthritis treated for up to ten and one-half months.[6,7]

Calcium and phosphorus

Phosphate excretion in animals[1] was not changed from normal even with amounts 25 times greater (by body weight) than those known to be clinically effective. Human metabolic balance studies[3] demonstrated that no change in calcium excretion occurred on dosages usually employed clinically when the compound is administered for its anti-inflammatory effect. Even at a dosage level twice this, slight negative balance appeared only during a short period.

Protein and nitrogen balance

Positive nitrogen balance was maintained during a human metabolic study on maintenance dosage of 12 mg. per day.[3] At dosages two to three times normal levels, positive balance was maintained except for occasional short periods in metabolic studies of several weeks' duration.[2,3]

There was always a tendency for normalization of the A/G ratio and elevation of blood albumin when ARISTOCORT was used in treating the nephrotic syndrome.[8]



Liver glycogen deposition and inflammatory processes

An intimate correlation exists between the ability of a corticosteroid to cause deposition of glycogen in the liver and its capacity to ameliorate inflammatory processes.

In animal liver glycogen studies, relative potencies of ARISTOCORT over cortisone of up to 40 to 1 have been observed. Compared to ARISTOCORT, five to 12 times the amount of prednisone is required to produce varying but equal amounts of glycogen deposition in the liver.[1]

Most patients show normal fasting blood sugars on ARISTOCORT. Diabetic patients on ARISTOCORT may require increased insulin dosage, and occasional latent diabetics may develop the overt disease.

Anti-inflammatory potency of ARISTOCORT was determined by both the asbestos pellet[1] and cottonball[9] tests. It was found to be nine to 10 times more effective than hydrocortisone in this respect.

Gastric acidity and pepsin

The precise mode of ulcerogenesis during treatment with corticosteroids is not known. There is much experimental evidence for believing this may be related to the tendency of these agents to increase gastric pepsin and acidity—and this cannot be abolished by vagotomy, anticholinergic drugs or gastric antral resection.[10] Clinical studies[11] of patients on ARISTOCORT revealed that uropepsin excretion is not elevated. Further, their basal acidity and gastric response to histamine stimulation were within normal limits.

Central nervous system

The tendency of corticosteroids to produce euphoria, nervousness, mental instability, occasional convulsions and psychosis is well known.[12] The mechanism underlying these disturbances is not well understood.

ARISTOCORT, on the contrary, does not produce a false sense of well being, insomnia or tension except in rare instances. In the treatment of 824 patients, for up to one year, not a single case of psychosis has been produced. In general, it appears to maintain psychic equilibrium without producing cerebral stimulation or depression.

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The Promise of Aristocort in Reduction of Side Effects

It is axiomatic to affirm that the undesirable collateral hormone effects of corticosteroids increase in frequency and severity the higher the dosage and the longer used.

It has also become well recognized that the most serious of the major side effects from long-term corticosteroid treatment are peptic ulcers, osteoporosis with fracture, drug psychosis and euphoria, and sodium and water retention leading often to general tissue edema and hypertension.

It is significant that of the close to 400 patients on the lower dosage schedules found effective in bronchial asthma and dermatologic conditions, only 1 case of peptic ulceration has developed. No other of the above side effects have been observed even though ARISTOCORT was administered continuously to them for periods as long as one year.

The treatment of rheumatoid arthritis with steroids appears to result in the highest incidence of side effects. For this reason, the side effects associated with ARISTOCORT therapy in 292 patients with rheumatoid arthritis are reported below.

Peptic Ulcer

The occurrence of peptic ulcer in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is approximately 1 per cent (2 of the 3 occurred in patients transferred from prednisone). In the remaining 532 cases recently analyzed, only one ulcer has been discovered in a patient who apparently had no ulcer when he was changed from another steroid.

Osteoporosis and Compression Fractures

The occurrence of osteoporosis with compression fracture in 292 patients with rheumatoid arthritis treated continuously for up to one year with ARISTOCORT is 0.33 per cent (1 case[1]). Although these results are encouraging, determination of the true incidence of osteoporosis will have to await the passage of more time.

Euphoria and Psychosis

The euphoria so commonly produced by all previous corticosteroids has seemed a most desirable attribute to patients. In penalty, however, they have often later to pay for this by mental disturbances, varying from mild and transitory to severe depression and psychosis,[2] and toxic syndromes producing even convulsions and death.[3]

Since the onset of these complications is not directly related to duration of steroid administration,[4] the fact that not one case of psychosis occurred in 824 patients treated with ARISTOCORT, is most encouraging.

Sodium Retention—Hypertension—Potassium Depletion

When 17 patients were changed from prednisone to ARISTOCORT, 11 rapidly lost weight although only one had had visible edema.[5] Sodium and water retention, hypokalemia or hyperkalemia and steroid hypertension did not appear in 194 rheumatoid arthritis patients treated with ARISTOCORT.[1,6]

The interrelation between blood and body sodium, and steroid hypertension has long been generally appreciated.[7,8] Except in rare instances, or when unusually high doses are used (e.g., leukemia), the problem of edema and hypertension caused by sodium and water retention, has been eliminated with ARISTOCORT.

Minor Side Effects

Collateral hormonal effects of less serious consequence occurred with approximately the same frequency as with the older corticosteroids.[1] These include erythema, easy bruising, acne, hypertrichosis, hot flashes and vertigo. Several investigators have reported symptoms not previously described as occurring with corticosteroid therapy, e.g., headaches, lightheadedness, tiredness, sleepiness and occasional weakness.

Moon facies and buffalo humping have been seen in some patients on ARISTOCORT. However, ARISTOCORT therapy, in many instances, resulted in diminution of "Cushingoid" signs induced by prior therapy. Where this occurs, it may be related to reduced dosage on which patients can be maintained.

Reduction of dosage by one-third to one-half

In a double-blind study of comparative dosage in patients with rheumatoid arthritis,[9] 70 per cent of the cases were as well controlled on a dose of ARISTOCORT one-half that of prednisone. A general recommendation can be made that ARISTOCORT be used in doses two-thirds that of prednisone or prednisolone in the treatment of rheumatoid arthritis. There are individual variations, however, and each patient should be carefully titrated to produce the desired amount of disease suppression.

Comparative studies, of patients changed from prednisone, indicate reduced dosage of ARISTOCORT in bronchial asthma and allergic rhinitis (33 per cent),[5] and in inflammatory and allergic skin diseases (33-50 per cent).[10,11]

General Precautions and Contraindications

Administration of ARISTOCORT has resulted in lower incidence of major serious side effects, and in fewer of the troublesome minor side effects known to occur with all previously available corticosteroids. However, since it is a highly potent glucocorticoid, with profound metabolic effects, all traditional contraindications to corticosteroid therapy should be observed.

No precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

Since ARISTOCORT has less of the traditional side effects, the appearance of sodium and water retention, potassium depletion, or steroid hypertension cannot be used as signs of overdosage. As a rule patients will lose some weight during the first few days of treatment as a result of urinary output, but then the weight levels off.

Patients do not develop the abnormally voracious appetite common to previous corticosteroid administration. In fact, some patients experienced anorexia, and it is advisable to inform patients of this and to recommend they maintain a normal intake of food, with emphasis on liberal protein intake.

While precipitation of diabetes, peptic ulcer, osteoporosis, and psychosis can be expected to appear rarely from ARISTOCORT, they must be searched for periodically in patients on long-term steroid therapy.

Traditional precautions should be observed in gradually discontinuing therapy, in meeting the increased stress of operation, injury and shock, and in the development of intercurrent infection.

There is one overriding principle to be observed in the treatment of any disease with ARISTOCORT. *The amount of the drug used should be carefully titrated to find the smallest possible dose which will suppress symptoms.*

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1. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957. 2. Bunim, J. J.: Bull. New York Acad. Med. 33:461, 1957. 3. Good, R. A., Vernier, R. L., and Smith, R. T.: Pediatrics *19*:95, 1957. 4. Goolker, P., and Schein, J.: Psychosom. Med. *15*:589, 1953. 5. Sherwood, H., and Cooke, R. A.: J. Allergy 28:97, 1957. 6. Hartung, E. F.: Personal Communication. 7. Schroeder, H. A.: J.A.M.A. *162*:1362, 1956. 8. Thorn, G. W., Laidlaw, J. C., and Goldfein, A.: Ciba Found. Coll. on Endocrinology, J. & A. Churchill, Ltd., London, 8:343, 1955. 9. Freeman, H., Bachrach, S., McGilpin, H. H., and Dorfman, R. I.: Personal Communication. 10. Rein, C. R., Fleischmajer, R., and Rosenthal, A.: J.A.M.A. *165*:1821, 1957. 11. Shelley, W. B., and Pillsbury, D. M.: Personal Communication.

Lederle

The Promise of Aristocort in Rheumatoid Arthritis

ARISTOCORT *therapy has been intensely and extensively studied for periods up to one year on 292 patients with rheumatoid arthritis.*

Significant is the fact that most patients were *severe* arthritics, transferred to ARISTOCORT from other corticosteroids because satisfactory remission had not been attained, or because the seriousness of collateral hormonal effects had made discontinuance desirable.

Results of treatment

Freyberg and associates[1] treated 89 patients with rheumatoid arthritis (A. R. A. Class II or III and Stage II or III). Of these, 51 were on ARISTOCORT therapy from three to over 10 months. In all but a few patients, satisfactory suppression of rheumatoid activity was obtained with 10 mg. per day. Thirteen were controlled on 6 mg. or less a day, and for periods to 180 days. The investigators reported therapeutic effect in most cases to be A. R. A. Grade II (impressive) and that marked reduction in sedimentation rates occurred.

Another interesting observation in this study: Of the 89 patients treated, 12 had active ulcers, developed from prior steroid therapy. *In six patients, the ulcers healed while on doses of* ARISTOCORT *sufficient to control arthritic symptoms.*

Hartung[2] treated 67 cases of rheumatoid arthritis for up to 10 months. He found the optimum maintenance dose to be 11 mg. per day. Nineteen of these patients were treated for six to 10 months with an "excellent" therapeutic response.

Dosage and course of therapy

The initial dosage range recommended is 14 to 20 mg. per day—depending on the severity and acuteness of signs and symptoms. Dosage is divided into four parts and given with meals and at bedtime. Anti-rheumatic effect may be evident as early as eight hours, and full response often obtained within 24 hours. This dosage schedule should be continued for two or three days, or until all acute manifestations of the disease have subsided, whichever is later.

The maintenance level is arrived at by reduction of the total daily dosage in decrements of 2 mg. every three days. The range of maintenance therapy has been found to be from 2 mg. to 15 mg. per day—with only a very occasional patient requiring as much as 20 mg. per day. Patients requiring more than this should not be long continued on steroid therapy.

The aim of corticosteroid therapy in rheumatoid arthritis is to suppress the disease only to the stage which will enable the patient to carry out the required activities of normal living or to obtain reasonable comfort. The maintenance dose of ARISTOCORT to achieve this end is arrived at while making full use of all other established methods of controlling the disease.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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1. Freyberg, R. H., Berntsen, C. A., and Hellman, L.: Paper presented at International Congress on Rheumatic Diseases, Toronto, June 25, 1957. 2. Hartung, E. F.: Paper presented at Florida Academy of General Practice, St. Petersburg, Florida, Nov. 2, 1957.

Lederle

The Promise of Aristocort in Respiratory Allergies

About 200 patients with respiratory allergies have been treated with ARISTOCORT *for continuous periods up to eight months.*

Results of treatment

Sherwood and Cooke[1,2] gave ARISTOCORT to 42 patients with bronchial asthma and allergic rhinitis. Average dose needed to control the asthmatic group was approximately 6 mg. per day (range, 2 to 14 mg.). Results, which were called "good to excellent" in all but four, were achieved on one-third less than similarly effective doses of prednisone or prednisolone.

The investigators noted other major improvements in ARISTOCORT therapy over the older steroids. There was no increase in blood pressure in any patient: *on the contrary, in 12 patients, there was reduction of pressure when they were transferred to* ARISTOCORT. One patient had required auxiliary antihypertensive drug therapy; over a nine-week period on ARISTOCORT, the pressure gradually fell from 206/100 to 136/79. In another case, the pressure slowly dropped from 205/105 to 154/86.

The number of cases in which these investigators tried ARISTOCORT in allergic rhinitis was not large enough to provide significant averages. However, the range of effective therapy was from 2 to 6 mg. per day. These strikingly low daily doses resulted in control of all signs and symptoms.

Schwartz[3] treated 30 patients with chronic, intractable bronchial asthma. At an average daily dose of 7 mg., he reported "good to excellent" results in all but one. Spies,[4] Barach[5] and Segal,[6] reported similar results at average daily maintenance doses of 4 to 10 mg. of ARISTOCORT.

Dosage and course of therapy

The initial dosage range recommended is 8 to 14 mg. of ARISTOCORT daily. Although a rare, very severe case may require more than this on the first day of therapy, these dosages will usually result in prompt alleviation of dyspnea, wheezing and cyanosis. Patients are soon able to carry out a normal span of daily activity.

The maintenance level is arrived at by reduction of the total daily dose every three days in decrements of 2 mg.; in the over-all series, the average daily dose for bronchial asthma is approximately 8 to 10 mg. and for allergic rhinitis, 2 to 6 mg. per day. All total daily doses should be divided into four parts and given with meals and at bedtime. As in every condition where corticosteroids are employed, each patient's treatment should be individualized and the maintenance arrived at by careful titration against signs and symptoms of disease.

Patients with chronic bronchial asthma may require steroid therapy for several months. And since asthma may be associated with cardiac disease, especially in the older age groups, ARISTOCORT is particularly useful because of its ability to cause excretion of sodium and water.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

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1. Sherwood, H., and Cooke, R. A.: J. Allergy 28:97, 1957. 2. Sherwood, H., and Cooke, R. A.: Personal Communication. 3. Schwartz, E.: Personal Communication. 4. Spies, T. D.: Personal Communication. 5. Barach, A. L.: Personal Communication. 6. Segal, M. S.: Personal Communication.

Lederle

The Promise of Aristocort

in Nephrotic Syndrome

◊ *Fourteen patients with the nephrotic syndrome have been treated with* ARISTOCORT *for continuous periods of up to six weeks.*

Results of treatment

Hellman and associates[1,2] noted that ARISTOCORT, because of its favorable electrolyte effects, may well be the most desirable steroid to date in treatment of the nephrotic syndrome. However, thus far its use has been reported in only 14 children, of whom 8 had a complete diuresis and disappearance of all abnormal chemical findings. Four of the patients had diuresis, but continued to show some abnormal chemical findings, while two patients with signs of chronic renal disease failed to respond.

Dosage and course of therapy

In order to produce maximal response, 20 mg. should be given daily until diuresis occurs. The dose should then be decreased gradually and maintained around 10 mg. a day. After the patient has been in remission for some time, it may be advisable to diminish the dose gradually and discontinue ARISTOCORT.

in Pulmonary Emphysema and Fibrosis

◊ *Eleven patients with pulmonary emphysema and/or fibrosis were treated with* ARISTOCORT *for continuous periods of over two months.*

Results of treatment

Only small series of cases observed by Barach,[3] Segal,[4] and Cooke,[5] are available. Barach treated patients who were not adequately controlled by prednisone, with the same dose of ARISTOCORT with significant improvement.

Dosage and course of therapy

The initial suppressive dose range recommended is 10-14 mg. daily. Frequently, there is a prompt decrease in cyanosis and dyspnea, with increase in vital capacity.

The average maintenance dose level was 8 mg. a day. If it is desired to maintain a patient on continuous therapy for some months, dosages as low as 2 mg. a day have been successful. All decreases in dosage should be gradual and at a rate of 2 mg. decrements in total daily amount, every two to four days. The daily dosage is divided into four parts and given with meals and at bedtime.



in Neoplastic Diseases

◊ *Forty-four children and adults have been given* ARISTOCORT *for palliative treatment of acute leukemia, chronic lymphatic leukemia, lymphosarcoma, lympholeukosarcoma and Hodgkin's disease.*

Results of treatment

Farber[6] has treated 22 children with acute leukemia for an average of three weeks. Of the 17 observed long enough to judge the efficacy of the medication, he rated five as excellent, three as good, two as fair and seven as poor responses.

Hellman and associates[7] gave ARISTOCORT to a group of patients with the various lymphomas in doses of 40 to 50 mg. a day—occasionally up to 100 milligrams. Treatment was continued in some cases for 17 weeks. Response was classified as good for the palliative purposes for which the drug was given.

Dosage and course of therapy

Massive initial suppressive doses of 40 to 50 mg. per day in children (1 mg./kg./day) and up to 100 mg. a day in adults have been administered.

Responses to any specific dosage in these conditions vary so widely that only a general dosage range can be indicated. Treatment must be individualized; rate of reduction in dosage and determination of maintenance levels cannot be categorized.

Miscellaneous

Patients with various other diseases have been treated by several clinical investigators. These include patients with osteoarthritis, acute bursitis, rheumatic fever, spondylitis, other "collagen-vascular" diseases (dermatomyositis, etc.), thrombocytopenic purpura, chronic eosinophilia, hemolytic anemia, diuretic-resistant congestive heart failures, and adrenogenital syndrome.

There have not been sufficient patients in any of the above categories to permit definitive treatment schedules to be finally established for ARISTOCORT. Additional studies are now in progress and physicians desiring information on any of these diseases are requested to write to Lederle Laboratories, Pearl River, New York for available data.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

Bibliography

1. Hellman, L., Zumoff, B., Kretshmer, N., and Kramer, B.: Presented at Nephrosis Conf., Bethesda, Md., Oct. 26, 1957. 2. Ibid: Personal Communication. 3. Barach, A. L: Personal Communication. 4. Segal, M. S.: Personal Communication. 5. Cooke, R. A.: Personal Communication. 6. Farber, S.: Personal Communication. 7. Hellman, L., Diamond, H. D., Ellison, R., Jaslowitz, B., Murphy, M. L.,Tan, C. and Zumoff, B.: Personal Communication.

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The Promise of Aristocort

in Inflammatory and Allergic Skin Diseases

◇ *Over 200 patients with allergic and inflammatory skin diseases (including psoriasis, atopic dermatitis, exfoliative dermatitis, pemphigus, dermatitis herpetiformis, eczematoid dermatitis, contact dermatitis and angioneurotic edema) have been treated continuously with* ARISTOCORT *for periods of up to eight months.*

Results of treatment

Rein and associates[1] treated 26 patients with severe dermatitis. Twenty-four had been on prednisone when changed to ARISTOCORT. While some had found satisfactory symptomatic relief, others had also developed side effects—moon face, buffalo hump, increased appetite with excessive weight increases and gastro-intestinal disturbances.

These investigators determined the equivalent dosage of ARISTOCORT to be approximately two-thirds that required to control symptoms on the previous corticosteroid. Thirteen of the 26, who had developed moon face, noted either an actual decrease or no further increase when transferred to ARISTOCORT. In addition: *Voracious appetites disappeared, with loss of weight in 11 patients; there was no elevation in blood pressure, and no necessity to restrict sodium or administer supplemental potassium.* Sherwood and Cooke,[2] and Shelley and Pillsbury[3] obtained similar results in allied disorders.

Hollander[4] first observed that ARISTOCORT appears to have striking affinity for the skin and great activity in controlling such diseases as psoriasis, for which other corticosteroids have been indifferently effective. Shelley and Pillsbury,[3] in 50 cases of acute extending psoriasis found that over 60 per cent were markedly improved.

Dosage and course of therapy

The recommended initial suppressive dose range is 14 to 20 mg. per day. In very severe cases, temporary dosages up to 32 mg. a day have been successfully employed. Once lesions are suppressed, gradually reduce dose to the maintenance level—which may be as low as 2 mg. per day.

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1. Rein, C. R., Fleischmajer, R., and Rosenthal, A.: J.A.M.A., *165*:1821, 1957. 2. Sherwood, H., and Cooke, R. A.: Personal Communication. 3. Shelley, W. B., and Pillsbury, D. M.: Personal Communication. 4. Hollander, J. L.: Discussion of Paper by Black, R. L., presented at International Congress on Rheumatic Diseases, Toronto, June 28, 1957.

in Disseminated Lupus Erythematosus

◇ *Forty patients with disseminated lupus erythematosus were treated with* ARISTOCORT *for continuous periods of up to nine months.*

Results of treatment

Patients have responded very promisingly to therapy. Dubois[1] has had the largest single experience (28 cases) with ARISTOCORT in the treatment of this disease. He reported 25 of the 28 responded favorably.

Freyberg,[2] Hartung,[3] Hollander,[4] Spies,[5] and Segal,[6] each in smaller series of cases, reported similarly good therapeutic responses.

Dosage and course of therapy

The initial suppressive dose recommended is 20-30 mg. daily. Once the desired effect is achieved, the dose should be reduced gradually to maintenance levels (3 to 18 mg. per day).

In severely ill patients large doses may be required for several days in order to preserve life. Even on these large doses, edema and sodium retention have not occurred.

ARISTOCORT is available in 2 mg. scored tablets (pink); 4 mg. scored tablets (white). Bottles of 30.

Bibliography

1. Dubois, E. L.: Personal Communication. 2. Freyberg, R. H.: Personal Communication. 3. Hartung, E. F.: Personal Communication. 4. Hollander, J. L.: Personal Communication. 5. Spies, T. D.: Personal Communication. 6. Segal, M. S.: Personal Communication.

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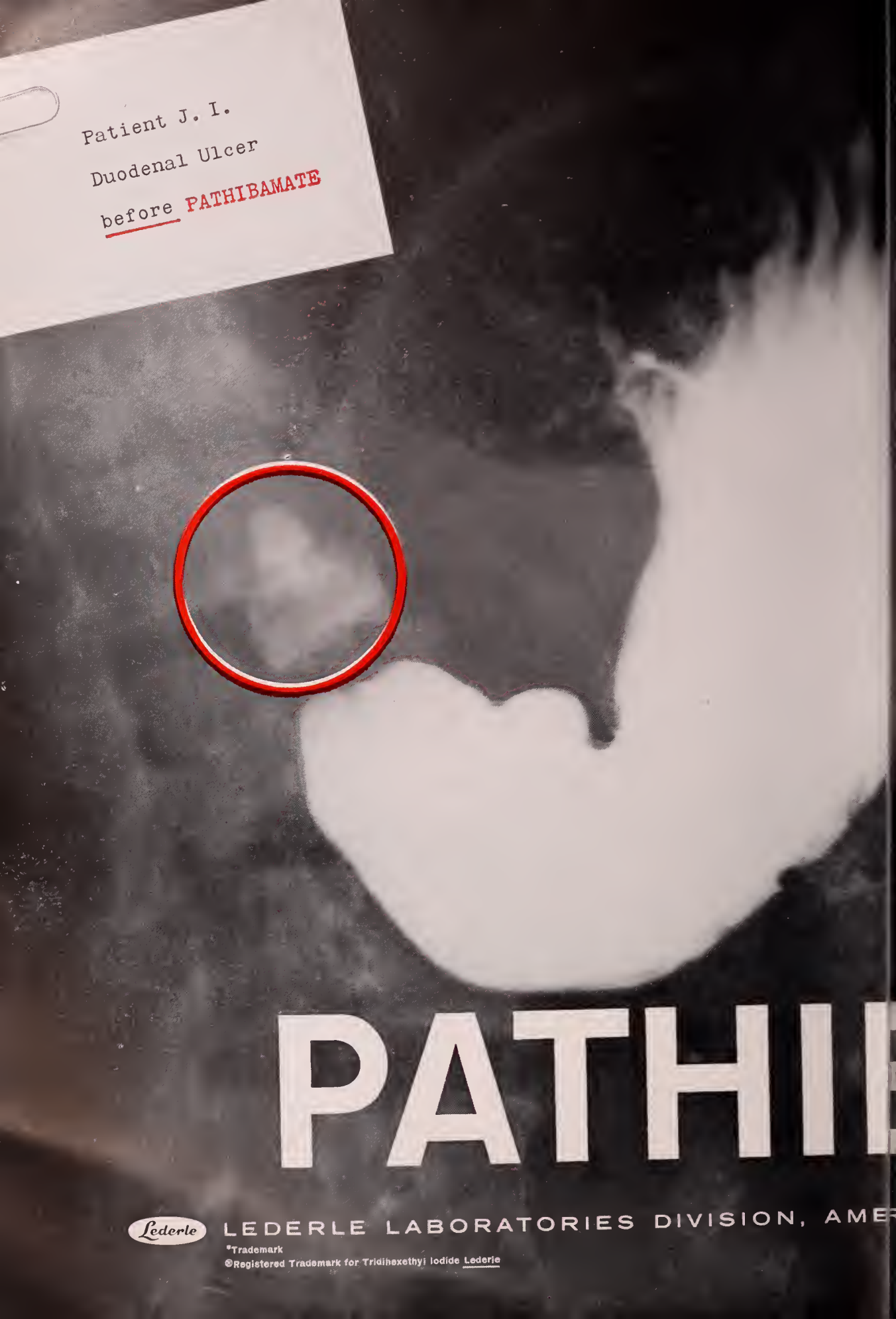
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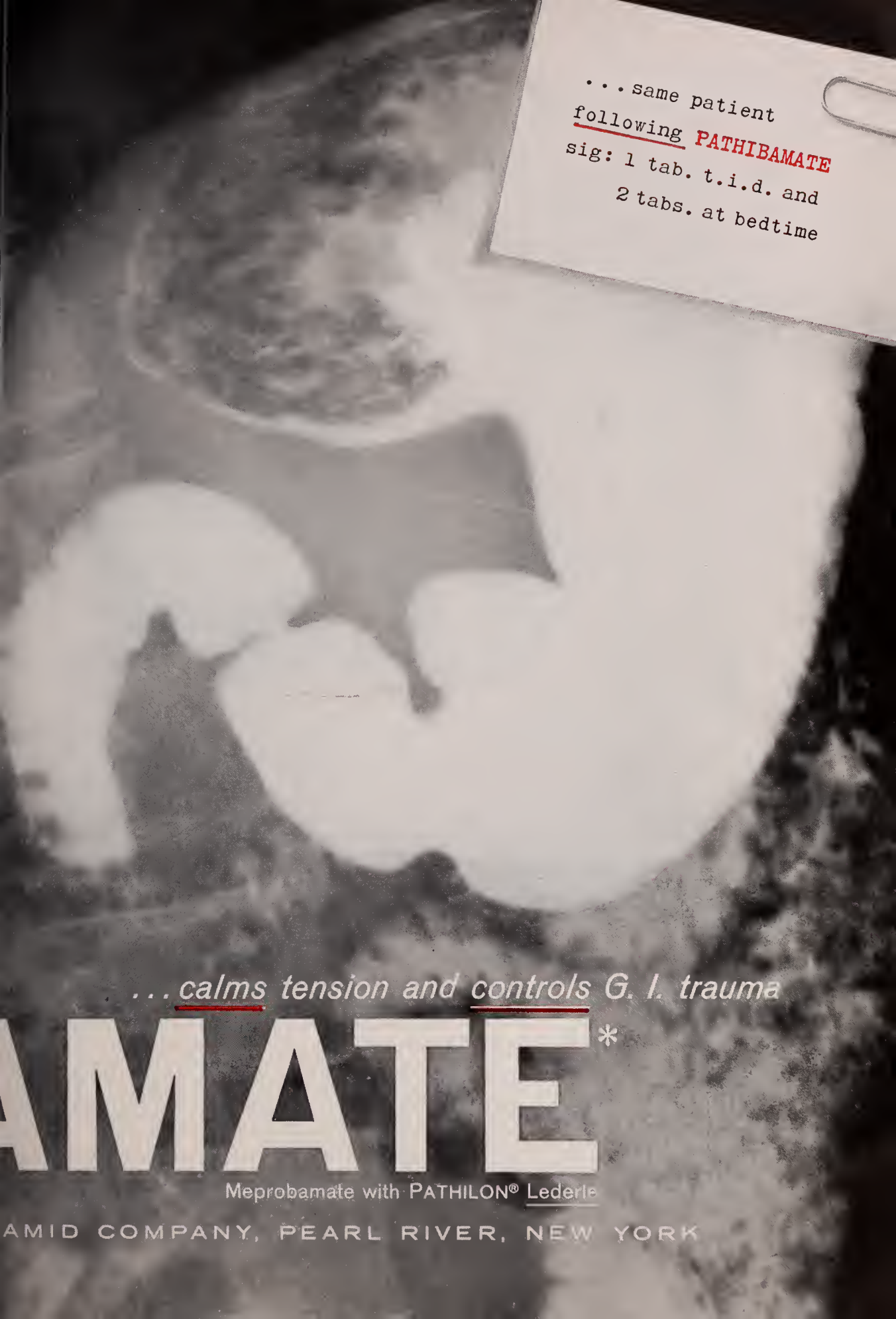
In recent years, a number of new synthetic anticholinergic drugs with numerous and varying side effects have been investigated for treatment of peptic ulcer. However, a double-blind study conducted recently by Cayer et al suggests that the use of such anticholinergic drugs is seldom necessary. The authors concluded that "The percentage of 'good to excellent' results obtained in patients on continuous long-term antacid therapy with DAA (74%) is essentially the same as that previously noted in ulcer patients treated under similar conditions with potent anticholinergic drugs alone."

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references: 1. Altschul, A. and Billow, B.: The clinical use of meprobamate. (Miltown®). New York J. Med. *57*: 2361, July 15, 1957. 2. Atwater, J. S.: The use of anticholinergic agents in peptic ulcer therapy. J. M. A. Georgia *45*:421, Oct. 1956. 3. Borrus, J. C.: Study of effect of Miltown (2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate) on psychiatric states. J. A. M. A. *157*:1596, April 30, 1955. 4. Cayer, D.: Prolonged anticholinergic therapy of duodenal ulcer. Am. J. Digest. Dis. *1*:301, July 1956. 5. Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Experimental studies of behavioral effects of meprobamate on normal subjects. Ann. New York Acad. Sc. *67*:701, May 9, 1957. 6. Phillips, R. E.: Use of meprobamate (Miltown®) for the treatment of emotional disorders. Am. Pract. & Digest Treat. *7*:1573, Oct. 1956. 7. Selling, L. S.: A clinical study of Miltown®, a new tranquilizing agent. J. Clin. & Exper. Psychopath. *17*:7, March 1956. 8. Wolff, S. and Wolff, H. G.: Human Gastric Function, Oxford University Press, New York, 1947.

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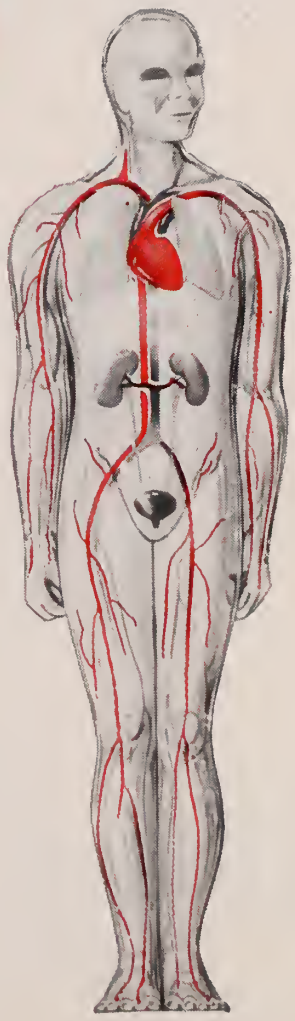
'DIURIL' is given in a dosage range of from 250 mg. twice a day to 500 mg. three times a day.

2 ADJUST DOSAGE OF OTHER AGENTS

The dosage of other antihypertensive medication (reserpine, hydralazine, etc.) is adjusted as indicated by patient response. If the patient is established on a ganglionic blocking agent (e.g., 'INVERSINE') this should be continued, but the total daily dose should be *immediately* reduced by 25 to 50 per cent. This will reduce the serious side effects often observed with ganglionic blockade.

3 ADJUST DOSAGE OF ALL MEDICATION

The patient must be frequently observed and careful adjustment of all agents should be made to determine optimal maintenance dosage.



BENEFITS:

- improves and simplifies the management of hypertension
- markedly enhances the effects of antihypertensive agents
- reduces dosage requirements for other antihypertensive agents—often below the level of distressing side effects
- smooths out blood pressure fluctuations

INDICATIONS: management of hypertension

Smooth, more trouble-free management of hypertension with 'DIURIL'

(Continued from page 1178)

economics, but to anyone who wants to understand good, healthy feeding. The science of nutrition is complex, and a working knowledge of the subject demands careful study. The purpose of the Manual is to supply information sufficient for this purpose. Originally written by Dr. Magnus Pyke, Ph.D., F.R.I.C., and first published in Great Britain in 1945, it grew out of a need arising during World War II for a program of nutrition education which would direct attention to the natural, healthy foods and the best way of serving them. The present fourth edition differs substantially from former editions, owing to the rapid advance in nutritional knowledge, and has been prepared by present members of the Scientific Adviser's Division (Food) of the Ministry of Agriculture, Fisheries and Food of Great Britain.

Ciba Foundation Symposium on the Chemistry and Biology of Purines. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc. Pp. 327. Illus. 124. Price, $9.00. Boston, Little, Brown and Company, 1957.

The study of purines has proceeded, until recently, along two lines: from the approach of the synthetic chemist and the point of view of the biochemist. Now, with an exchange of views a collaborative reorientation is producing valuable results. This symposium, therefore, is an important record of current thought on purines voiced by workers in both disciplines. This cooperative approach of biochemists and synthetic chemists points to the possible development of new chemotherapeutic agents whose activity depends upon their purine structure.

Recent, striking advances have been made in the biosynthesis of nucleic acid; and the knowledge gained in elucidating this problem opens the prospect of fundamental research into chemotherapy. Considerable progress has also been made in the enzymology of purines and their complex derivatives. One or two drugs of some clinical value have already been discovered as a by-product of a particular line of research. To the discovery of vitamin B_{12} and its purine-containing analogues can be added the trypanocidal and antitumor activity of puromycin and the possible use of adenine and its esters in vascular disorders.

Biologists generally will be interested in this volume because of its broad applicability. Those in cancer research and genetics will find it especially timely.

Vital Statistics of the United States 1954. Volume I. Pp. 358. Price, $3.75. Volume II. Pp. 505. Price, $4.00. Washington, D. C., United States Government Printing Office, 1956.

These volumes, prepared under the supervision of Halbert L. Dunn, M.D., Chief of the National Office of Vital Statistics, present final vital statistics for the United States, its Territories, and two possessions for the year 1954. Their subject matter consists of vital events that occurred in these areas during the year—marriages, divorces, births, fetal deaths, infant deaths, and deaths among the general population.

This annual report is organized as follows: Volume I. Introduction and Summary Tables. Tables containing data for Alaska, Hawaii, the Commonwealth of Puerto Rico, and the Virgin Islands (U.S.). Marriage, Divorce, Natality, Fetal Mortality, and Infant Mortality

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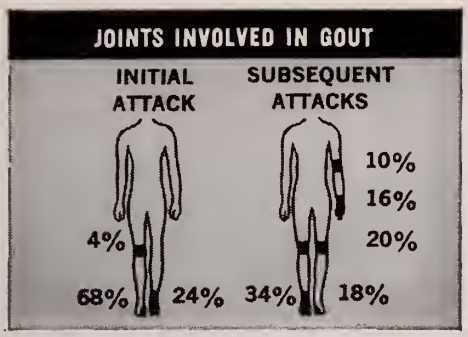
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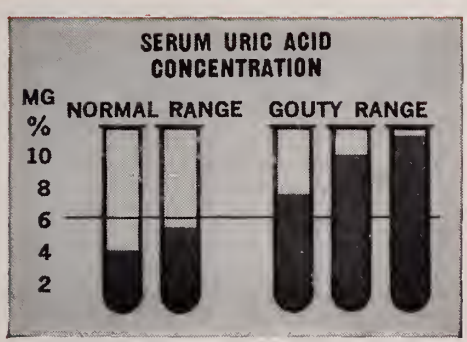
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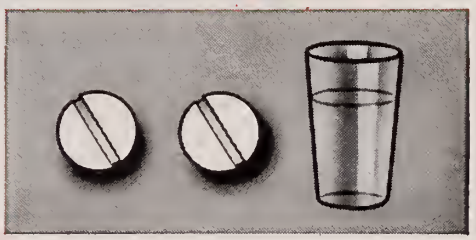
1. Recurrent joint pain followed by long periods of complete remission. *(Percentages refer to incidence.)*



2. Enlargement of bursae such as in this case involving the olecranon bursa.



3. Elevated serum uric acid levels.



4. Colchicine test: full dose (0.5 mg.) every 1 to 2 hours until pain is relieved or nausea, vomiting or diarrhea occur. The test requires usually 8 to 16 doses. Pain relief is highly indicative of gout.

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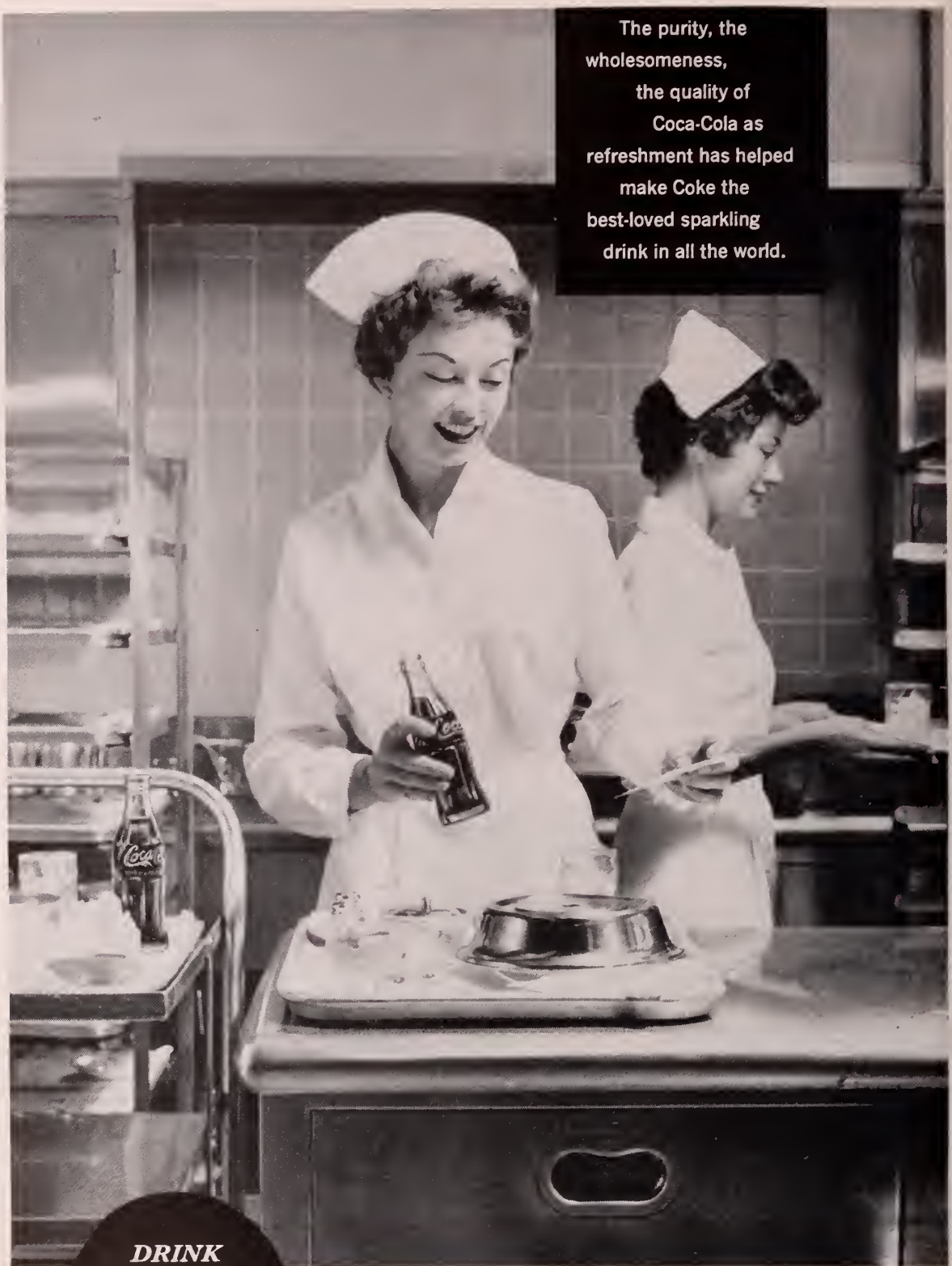
- Urinary excretion of uric acid is approximately doubled.
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Data for the United States and each State. Volume II. Mortality Data for the United States and each State.

In using statistics from either volume, it is recommended that reference be made to the explanatory text in Volume I, which describes the sources and limitations of the data.

Primera Conferencia Inter-Americana de Medicina del Trabajo Patrocinada por la Escuela de Medicina de la Universidad de Miami, Coral Gables, Florida, E. U. de Norte America y por la Facultad de Medicina de la Universidad de la Habana, Cuba, 3-6 Septiembre, 1956. Pp. 251. Coral Gables, University of Miami, 1957.

The organization and presentation of the Primera Conferencia Inter-Americana de Medicina del Trabajo was undertaken as a joint enterprise of the University of Miami School of Medicine and the University of Havana Faculty of Medicine and Pharmacy. The proceedings of this Conference are here presented.

This Conference represents one of many efforts of the University of Miami through the years to encourage cooperative educational and cultural programs with countries of the Caribbean, and South and Central America. In the Foreword of the proceedings, Dean Homer F. Marsh of the University of Miami School of Medicine comments: "As the School of Medicine came into being in this natural gateway to the Latin-Americas, it became the medical education facility of continental United States most proximal to the medical centers of the southern hemisphere, long influenced by European thinking in Medicine. Personal contacts with medical personnel in the Caribbean and South America led to the thought that our School and that of the University of Havana could become terminal anchors of a bridge linking the two hemispheres. Across such a bridge could flow a two-way traffic of benefits to be derived from informal discussion of mutual medical problems, continuing post-graduate education efforts, and development of interrelated research programs. The Conference reported herein is the first joint effort to bring into reality, this thought. In keeping with the philosophy of creating an atmosphere of friendship, the official language of the Conference was designated as Spanish. This decision probably was instrumental in attracting attendees from such widely separated countries as Puerto Rico and Spain in the East, Mexico in the West, and Peru and Chile in the South."

The program of the Thirty-First Annual Meeting of the Woman's Auxiliary to the Florida Medical Association is published in this issue of The Journal on page 1118.

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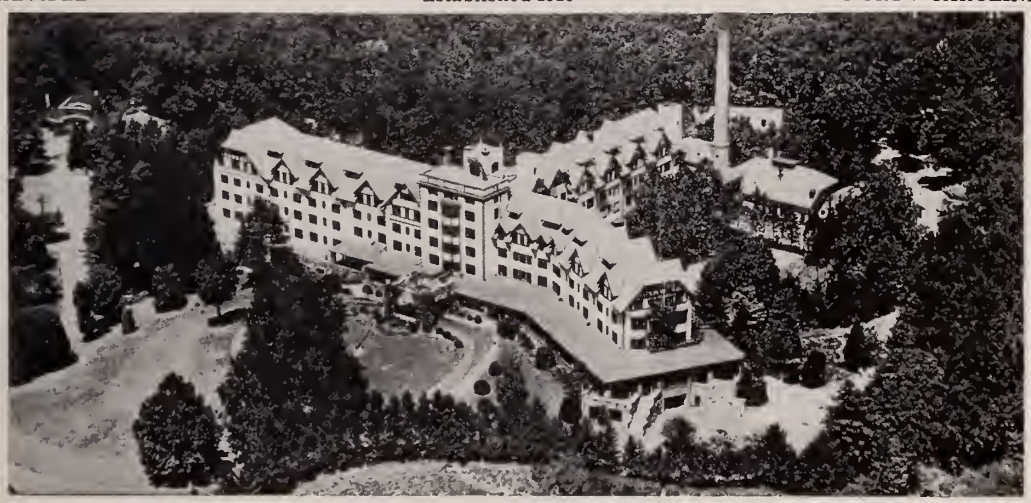
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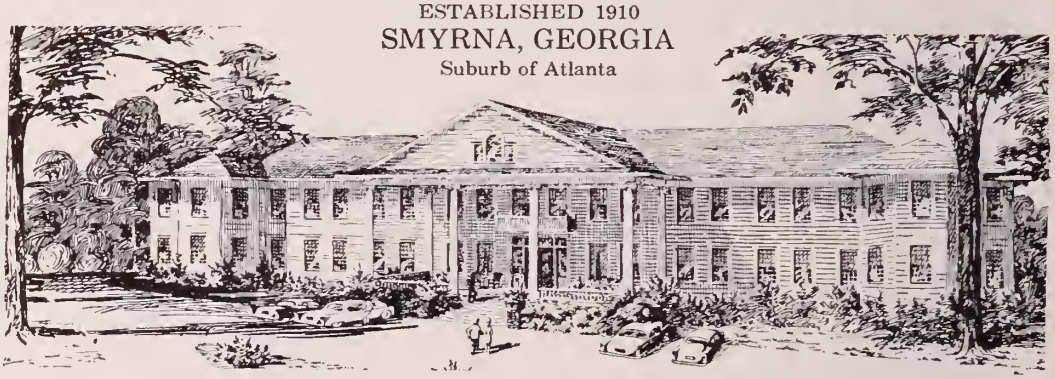
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st Phys., Am. Coll., Fla. Chap.	Clarence M. Sharp, Jacksonville	M. Eugene Flipse, Miami	" " " "
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alth Officers' Society	Paul W. Hughes, Ft. Lauderdale	Lorenzo L. Parks, Jacksonville	Miami Beach, May 1958
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A.M.A. Clinical Session			Minneapolis, Dec. 2-5, '58
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HERBERT E. WHITE, M.D., 1950.....St. Augustine
DAVID R. MURPHEY JR., M.D., 1951.....Tampa
ROBERT B. McIVER, M.D., 1952.....Jacksonville
FREDERICK K. HERPEL, M.D., 1953.....W. Palm Beach
DUNCAN T. McEWAN, M.D., 1954.....Orlando
JOHN D. MILTON, M.D., 1955.....Miami
FRANCIS H. LANGLEY, M.D., Secy., 1956.....St. Petersburg

County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	ACTIVE MEMBERS
Alachua	G. Leonard Emmel, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	64
* *Bradford, Gilchrist, Union*				
Bay	Sidney E. Daffin, Panama City	Henry C. Smallwood, Panama City	1st Tues.	29
Brevard	Jack T. Bechtel, Eau Gallie	Cyrus E. Warden, Melbourne	2nd Tues.	53
Broward	Russell R. Hippensteel, Hollywood	Garland M. Johnson, Ft. Lauderdale	4th Tues.	182
Collier	Reidar Trygstad, Naples	Ethel H. Trygstad, Naples	3rd Wed.	9
Columbia	Robert M. Sasso, Lake City	Louis G. Landrum, Lake City	1st Mon.	11
* *Baker*				
Dade	Nelson Zivitz, Miami	Geo. W. Robertson III, Miami	1st Tues.	808
DeSoto-Hardee-Highlands-Glades	Charles H. Kirkpatrick, Arcadia	Gordon H. McSwain, Arcadia	1st Tues.	28
Duval	Ashbel C. Williams, Jacksonville	William J. Knauer Jr., Jacksonville	1st Tues.	334
* *Clay*				
Escambia	Joseph W. Douglas, Pensacola	Joseph Q. Perry, Pensacola	2nd Tues.	113
Franklin-Gulf	William F. Wager, Port St. Joe	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	Wesley W. Wilson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	225
Indian River	Enoch J. Vann Jr., Vero Beach	Charles F. Rattray, Vero Beach	2nd Tues.	9
Jackson-Calhoun	Sarah M. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	15
Lake	Geo. E. Engelhard, Leesburg	Frederick C. Andrews, Mt. Dora	1st Wed.	26
* *Sumter*				
Lee-Charlotte-Hendry	Gustave F. Bieber, Ft. Myers	William M. Taylor, Ft. Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	T. Bert Fletcher Jr., Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	72
Madison	Wilmer J. Coggins, Madison	Julian M. DuRant, Madison	Quarterly	8
Manatee	Eugene E. Biel, Bradenton	Irving E. Hall Jr., Bradenton	2nd Tues.	31
Marion	Harry M. Edwards, Ocala	Charles H. Marks, Ocala	3rd Tues.	33
* *Levy*				
Monroe	William R. Ploss, Key West	Walter R. McCook, Key West	1st Thurs.	13
Nassau	Benjamin F. Dickens, Fernandina Bch.	David D. Bennett, Callahan	1st Thurs.	8
Orange	Robert E. Zellner, Orlando	Robert W. Curry, Orlando	3rd Wed.	219
* *Osceola*				
Palm Beach	W. Lawson Shackelford, W. Palm Bch.	Robert Y. Wheelihan, Riviera Bch.	4th Mon.	162
Pasco-Hernando-Citrus	S. Carnes Harvard, Brooksville	W. Wardlaw Jones, Dade City	2nd Thurs.	20
Pinellas	Whitman H. McConnell, St. Pete	Whitman C. McConnell, St. Pete	1st Mon.	253
Polk	Marion W. Hester, Lakeland	Charles Larsen Jr., Lakeland	2nd Wed.	111
Putnam	Bennie J. Massey, Palatka	Fairfax E. Montague, Palatka	2nd Tues.	10
St. Johns	Thomas L. Glennan, Green Cove Spgs.	Walter W. Weigel, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Howard C. McDermid, Ft. Pierce	Maltby F. Watkins, Ft. Pierce	3rd Thurs.	29
Sarasota	Karl R. Rolls, Sarasota	James E. Kicklighter, Sarasota	2nd Tues.	67
Seminole	Daniel H. Mathers, Sanford	Terry Bird, Sanford	2nd Tues.	15
Suwannee-Hamilton-Lafayette	Irby H. Black, Live Oak	Hugo F. Sotolongo, Live Oak	1st Sat.	11
Taylor	John A. Dyal Jr., Perry	Charles R. Wiley, Perry	Last Fri.	6
* *Dixie*				
Volusia	Achille A. Monaco, Daytona Bch.	John J. Cheleden, Daytona Bch.	2nd Tues.	86
* *Flagler*				
Walton-Okaloosa-Santa Rosa	Howard A. Parker, Valparaiso	Eric F. Geiger, Milton	3rd Tues.	27
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay		3
			Total	3,154

* *Supervise and aid until organized separately.*

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Ford, R. V., and Moyer, J. H.: Rauwolfia Toxicity in the Treatment of Hypertension, Postgrad. Med. 23:41 (Jan.) 1958.

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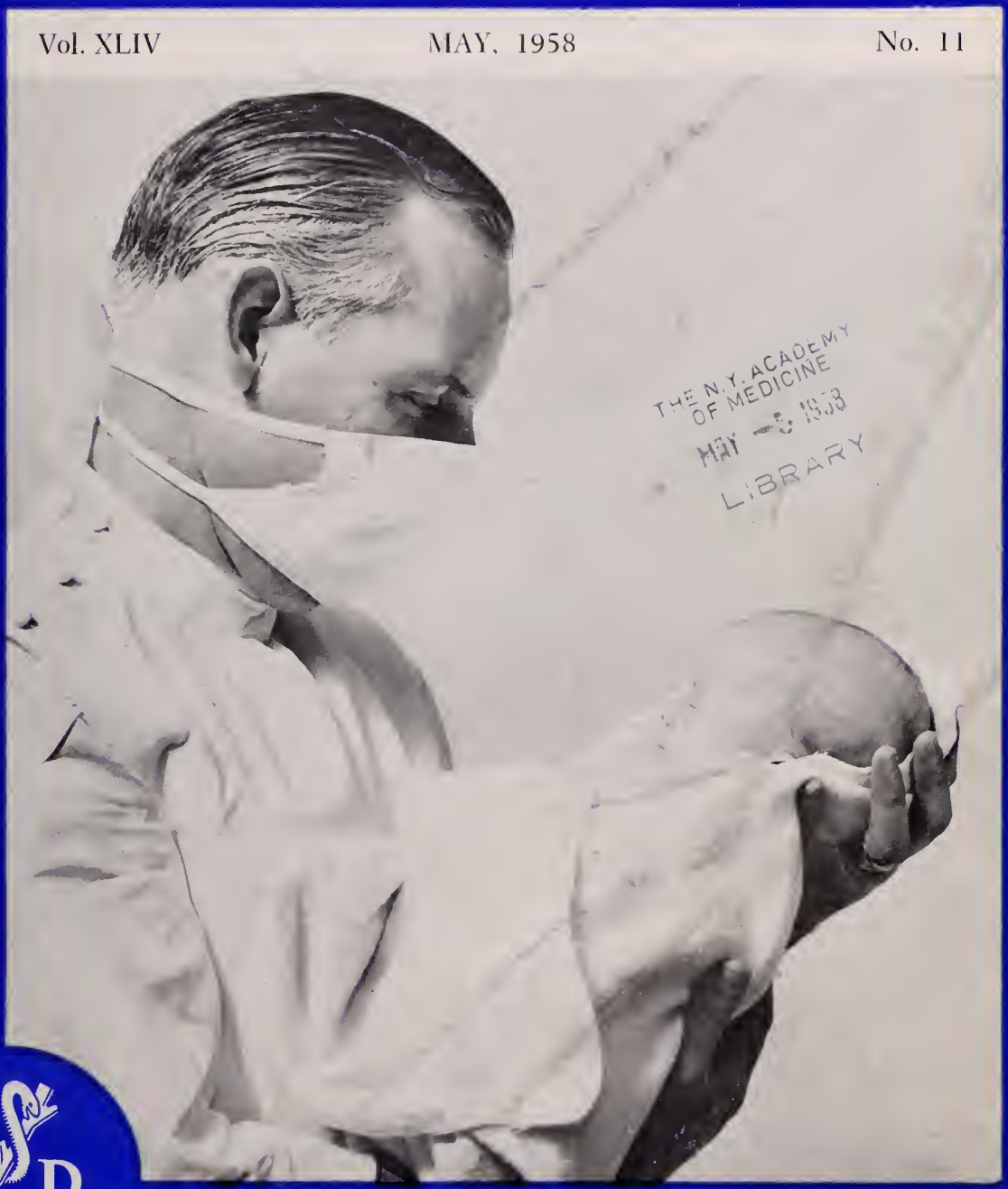
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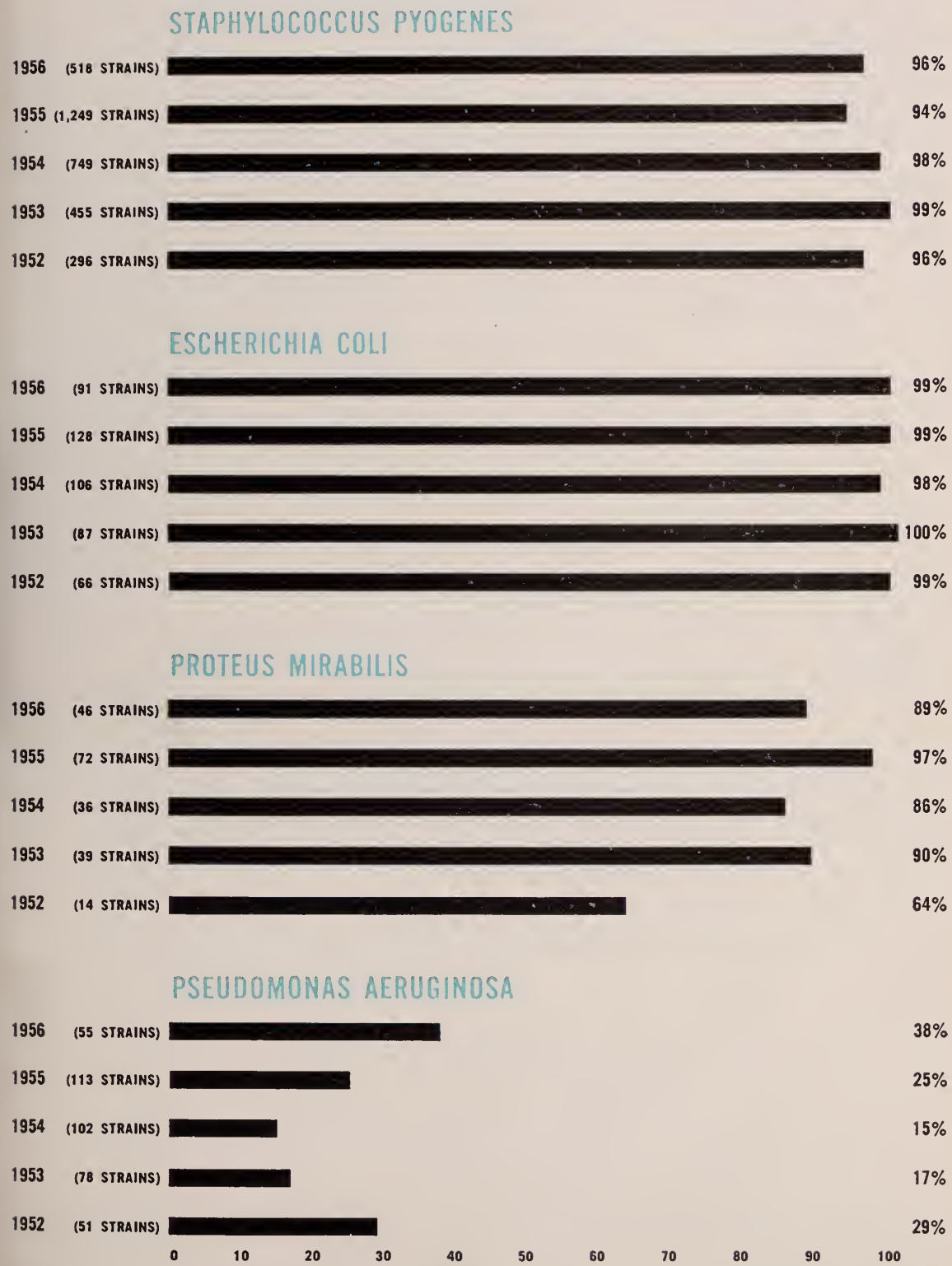
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REFERENCES: (1) Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M.A.J.* 77:844 (Nov. 1) 1957. (2) Schneierson, S. S. *J. Mount Sinai Hosp.* 25:52 (Jan.-Feb.) 1958. (3) Koch, R., & Donnell, G.: *California Med.* 87:313, 1957. (4) Waisbren, B. A., & Strelitzer, C. L.: A Five-Year Study of the Antibiotic Sensitivities and Cross Resistances of Staphylococci in a General Hospital, paper presented at Fifth Ann. Symp. on Antibiotics, Washington, D. C., Oct. 2-4, 1957. (5) Doniger, D. E., & Parenteau, Sr. C. M.: *J. Maine M. A.* 48:120, 1957. (6) Royer, A.: Changes in Resistance to Various Antibiotics of Staphylococci and Other Microbes, paper presented at Fifth Ann. Symp. on Antibiotics, Washington, D. C., Oct. 2-4, 1957. (7) Hasenclever, H. F: *J. Iowa M. Soc.* 47:136, 1957. (8) Josephson, J. E., & Butler, R. W.: *Canad. M.A.J.* 77:567 (Sept. 15) 1957. (9) Rhoads, P. S.: *Postgrad. Med.* 21:563, 1957. (10) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 29:159, 1957.

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*Adapted from Roy and others.[1]

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VOLUME XLIV, No. 11 • *May, 1958*

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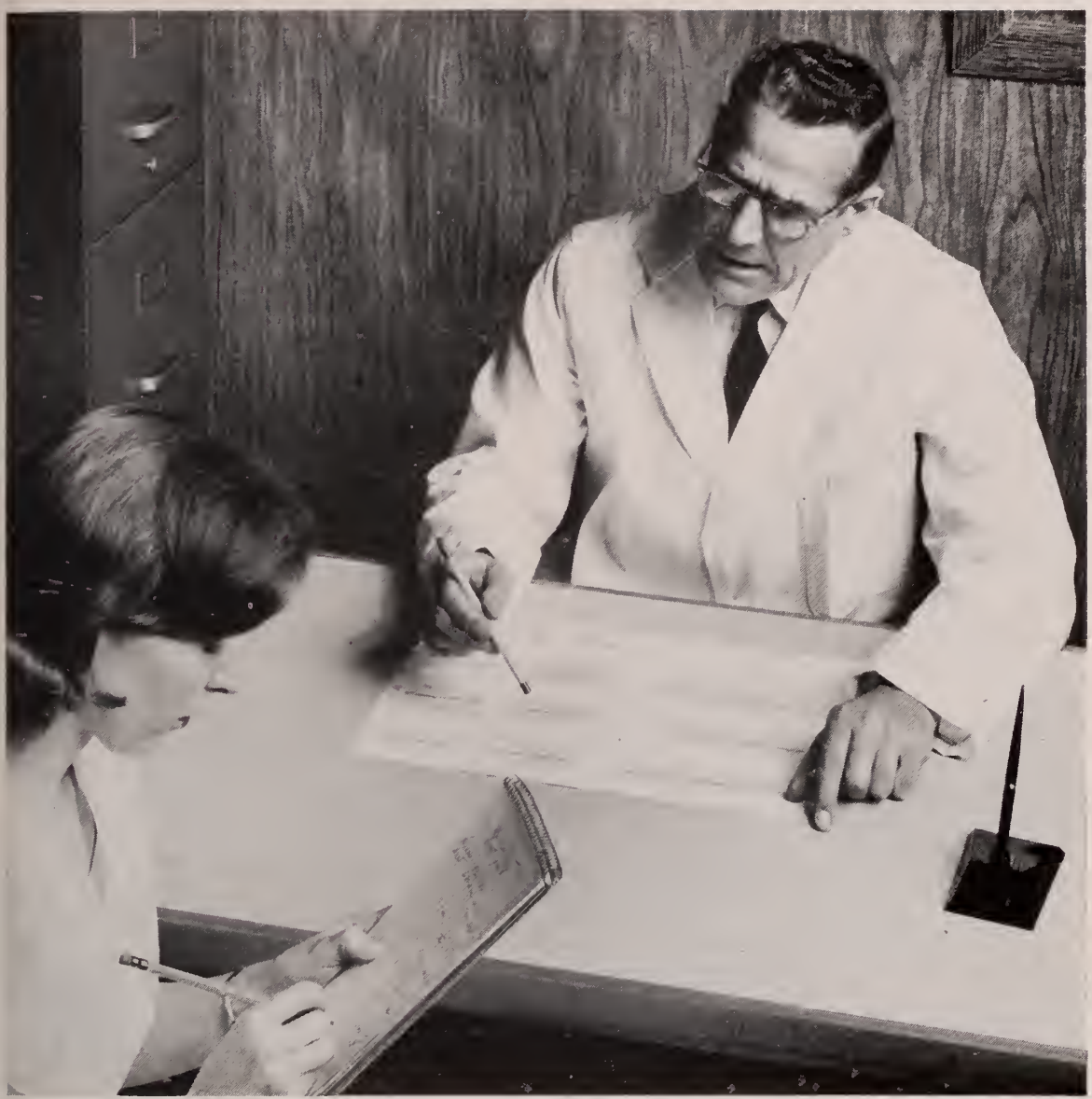
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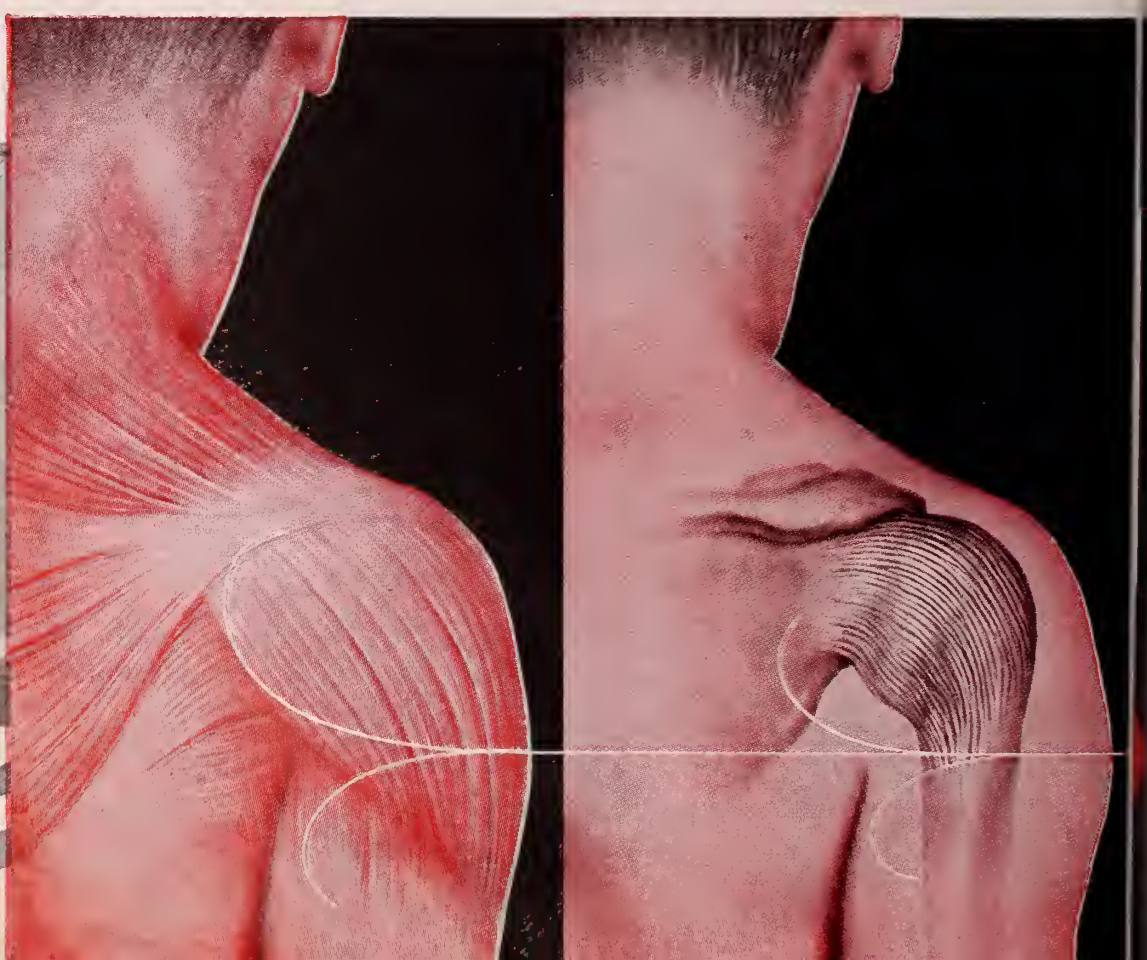
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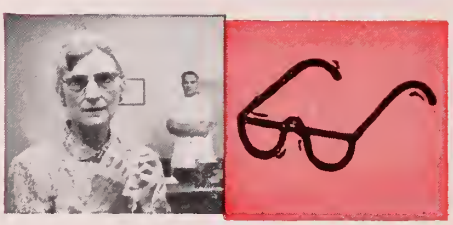
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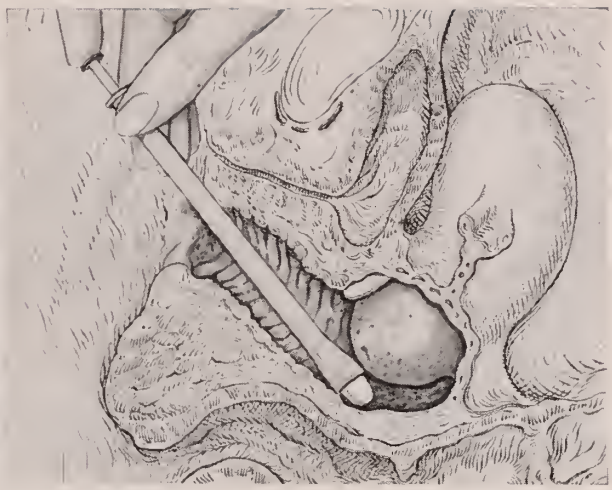
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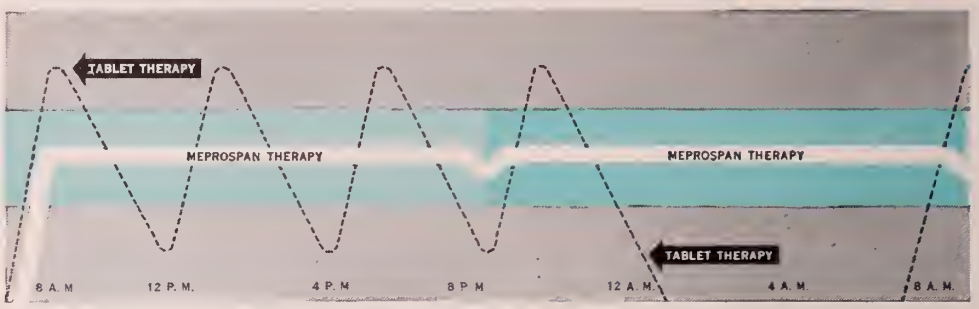
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*Williamson, P.: Trichomonad Infestation, M. Times *84*:929 (Sept.) 1956.

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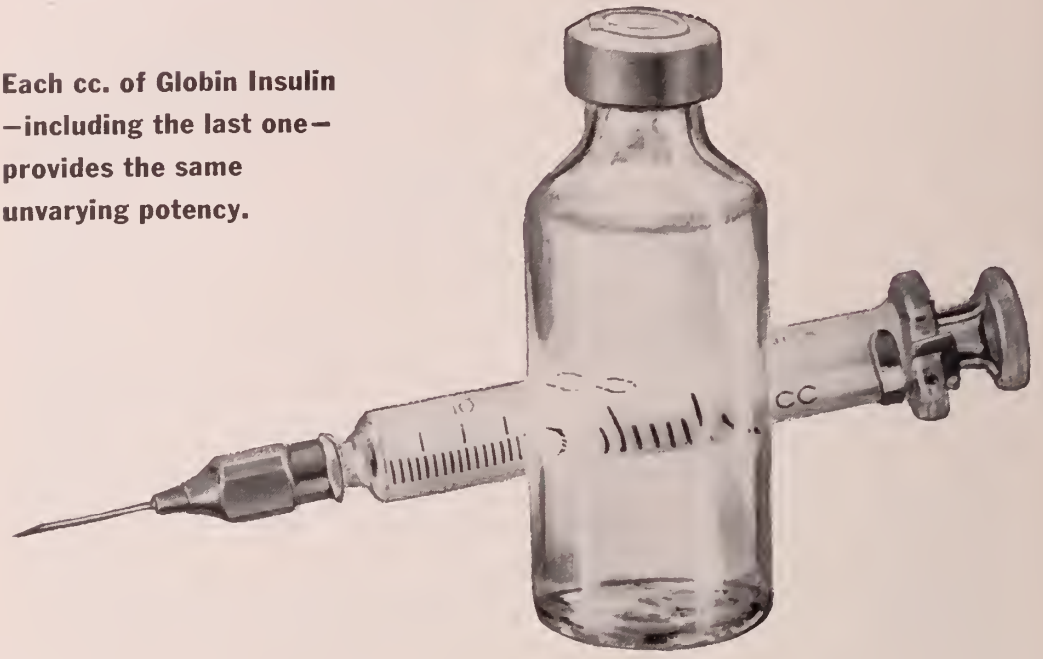


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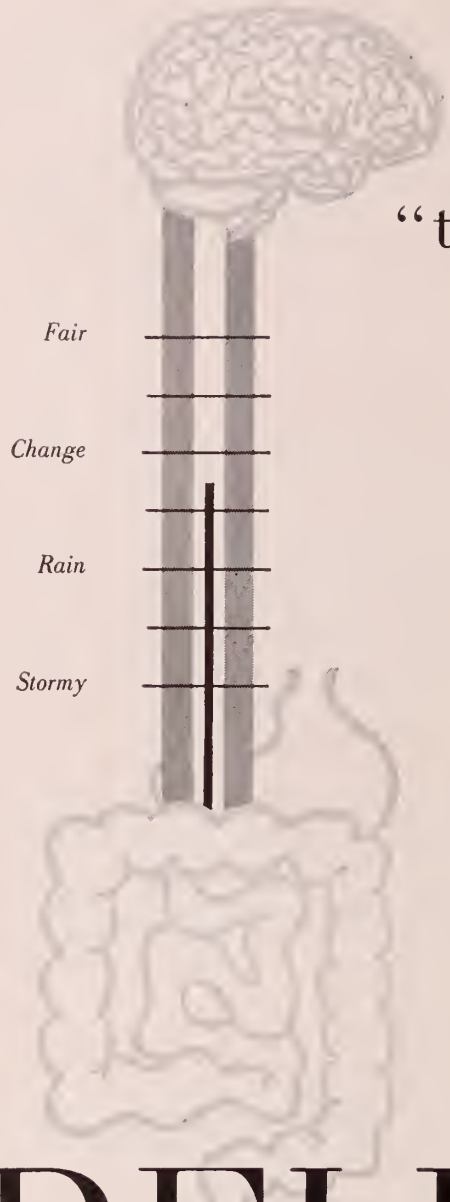


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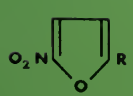
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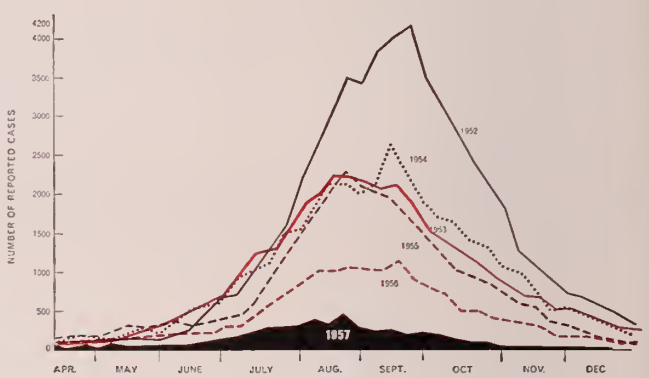
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1. *J. A. M. A.*, 165:21 (November 23), 1957.
2. *Department of Health, Education, and Welfare: News Release, October 10, 1957.*

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The Journal of The Florida Medical Association
PUBLISHED MONTHLY

Volume XLIV | Jacksonville, Florida, May, 1958 | No. 11

Guiding Principles for Continuing Pediatric Supervision of Children

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Pediatricians have an enviable record among modern medical specialists for retaining the outstanding assets of the old time family physician while advancing in the forefront of modern scientific medicine. These specialists are like general practitioners in being personal physicians to children and in having a strong interest in each child's family. They differ, first, in not providing medical care for older members of the family, and secondly, in utilizing more specialists' services for their patients in order to assure them full advantage of the advances and skills of modern scientific medicine. In doing this they do not or should not relinquish personal concern for the total well-being of the child during these episodes. At best, the pediatrician's focus of interest is on the child—the child in process of becoming a man—in health and in illness and not merely on the diseases which occur in childhood.

The pediatrician must be an expert in his understanding of children and of what constitutes health, age by age, in childhood, as well as in disease as it manifests itself at each stage or age period. Furthermore, since a child does not grow and develop in isolation or in a vacuum, as Dr. Wolf put it, the pediatrician must have knowledge of and be sensitive to the impacts of the family, the home, and the physical, social and psychologic components of the community upon the child, with particular reference to his health and development. This is a large order but a challenging and fascinating one. It disturbs me sometimes to have former students in pediatrics return and talk about their practice in a rather gloomy way, saying they never see any of the very interesting, rare or difficult diseases they used to see in the hospital. Their practice gets to be too routine, just seeing many children every day and answering questions about common problems. To me, the opportunity of being a guide and counselor to those who are helping children to grow and develop without unnecessary hindrances to a full and adequate maturity in the best possible physical, mental and emotional health should be interesting and satisfying to all who like children. The opportunity to follow the same child over long periods of time should create new interests, and later on becoming the physician to an adolescent can be extremely challenging.

At this hour I propose to discuss what I believe the pediatrician should be attempting to do when he is following children periodically in his practice and rendering what we call health services, in addition to caring for them in illness. I will not consider the goals in the care of the sick child, but will simply point out that health services are importantly related to the illnesses of childhood and that the pediatrician is fortunate in being able to provide both types of care and thus to consider their interrelationships.

In discussing health services, I will state some general principles which I believe should be kept constantly in mind in dealing with well children. Also, I will state some of the common characteristics or principles which seem to govern the progress of growth and development in childhood.

Broad View of Child Health

My first principle is that we should take a broad view of child health, that is, be concerned with total health—physical, physiologic, mental, and emotional. All of these aspects of health and development have important interrelationships. One cannot deal effectively with a feeding problem without considering many factors which have led to its development. This broad view should not only consider all aspects of the child himself but should take into account as far as possible the characteristics and attributes of the parents and others in the family constellation, and many aspects of the environment and care of the child concerned. It requires considerable interest, understanding and experience to assure adequate

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Read before the Florida Pediatric Society, Fall Meeting, Clearwater, Nov. 1, 1956.

knowledge of these related subjects, but this undertaking is greatly facilitated by periodic contacts and is contributed to greatly by adequate interval histories and observant examinations.

Long Range View

My second principle is to take the long range view and not to consider solely the immediate implications of present problems or occurrences. Oftentimes these are viewed as isolated events which in reality are part of a galaxy of continuous events with a common denominator. Poor habits, constitutional weaknesses, and many other factors which explain a child's recurrent problems are the things that one wants to recognize and deal with and not just periodically provide palliative treatment or advice for momentary management. As an example, consider accidents. The treatment of the damage resulting from the accident is, of course, the first objective. It is often important, however, to consider the cause, particularly when a child has frequent accidents. Is it because of carelessness, either on the part of the parents or of the child himself? Is it due to some physical disability or individual attribute, such as lack of coordination, or is it lack of information or awareness of what leads to accidents? Furthermore, the fact that the child needs medical treatment because of an accident makes this an ideal time to raise these questions with mother and child and to help them understand how to avoid future accidents and what to do in case they occur.

This long range type of thinking requires cultivation on the part of the physician. The young pediatrician has particular difficulty in taking this view because of lack of experience with individuals over long periods of time. Because of lack of facts we all have difficulty taking a position about the future significance of many present findings. This is essentially why I undertook 26 years ago to set up what we have called longitudinal studies of child health and development. The importance we attach to many findings on physical examination or occurrences reported in history taking depends upon whether they are transient and will be outgrown or whether they are permanent attributes which will influence physical well-being throughout the individual's life. Certainly this applies to obesity in childhood and other subjects which we hope to talk more about later.

Balanced View

The third principle I want to enunciate is that each of us must maintain a balanced view of all areas of health. This principle should be applied in respect to the relative importance of various factors and to their present and future significance. It involves avoiding riding our own hobbies. It applies to every one of us, for we all have our special interests and tend to forget the importance of other things that have failed to arouse our interest. It also involves avoiding waves of popular interest and often requires concerted effort to broaden the mother's interests, helping her to avoid riding her hobbies. The physician must frequently wean the mother away from concentration on or obsession with something she thinks is important to the neglect of other matters which may be of greater importance.

Educate Parents and Child

My fourth principle is that a continuing objective should be to educate parents in matters of child health and, later on, to educate the child himself. This does not mean didactic instruction but rather broadening of their understanding and encouragement of their thinking for themselves on the basis of accurate information. I believe pediatricians can do a great deal to help parents, most of whom want to give their children good care. They want to understand their children and meet their needs, and usually are so hungry for this knowledge that they read all sorts of literature about children and their care. What they read may be good, bad, or indifferent, but it must be presented to them on the basis of children in general, and not in any sense, of course, related to their own child and his individual needs. It seems to me that this service on the part of the pediatrician involves chiefly explanation and guidance, particularly as one takes the history and carries out the examination.

The understanding of a child and his personal characteristics and needs can only be conveyed after the physician has acquired such an understanding for himself. Otherwise, it is the blind leading the blind. This means that we should try as a matter of habit to get to recognize the child's aptitudes, significant characteristics, and so forth, through our history, examination, and continuing record of events. Only then can we undertake to convey to the parents such knowledge of the characteristics of their own child which will help them to do the best possible job for him. This knowledge must be kept abreast of

the child's changes with each stage of development.

I have become tremendously impressed with the serious attention which the adolescent will give to the physician when he talks—and if he talks to him at his level—as he takes the history and conducts the examination. Dr. Wolf pointed out that the adolescent is naturally interested in himself. He will worry about the most minor things, and he is eager to have someone whom he respects and can talk with and ask questions which he would not dream of asking his parents, his peers, or his teachers. My own personal feeling is that pediatricians make a great mistake when they drop children whom they have been following since birth, and know intimately, just at the time when the child is going through the rapid and confusing changes of pubescence and is trying to become independent and yearning for information about himself. If the break in this relationship occurs at this time, it is not likely that another doctor will be turned to for this purpose for a long time.

Recognizing Intrinsic Assets and Liabilities

My fifth principle to some extent is an extension and implementation of those already discussed. It is that the physician, in taking histories and carrying out examinations, should be alert to recognize evidences of particular assets and liabilities which appear to be intrinsic characteristics with which the child will have to learn to live. The former deserve cultivation whereas the latter need to be dealt with in the most satisfactory way to minimize handicaps. Body build, particularly when extreme, has a great deal to do with a child's physical problems and physical requirements. Size, pattern of growth, and particularly early or late maturation have tremendous impact on the older child. Constitutional weaknesses, which are particularly troublesome in adolescence, should be brought into the open and discussed at an appropriate time. Many children enjoy far less physical fitness or general good health than their potentialities would permit. This may be due to a variety of faulty habits, such as physical inactivity, excess of various sorts, or inappropriate diet. Part of good health service includes recognition and differentiation of these, followed by explanation and an attempt to motivate change.

Total Health Service for Handicapped Child

The sixth and final principle I want to mention in this series may be stated thus: provide total health service for the child with a specific defect or disability, that is, for the crippled or otherwise handicapped child. Obviously, for such a child physical fitness and good general health are more important than for the normal child. The trouble is that the handicap often becomes a fixation for mother, father, pediatrician, and other specialists alike. A specific defect or crippling condition usually leads to a variety of handicaps or related special problems, all of which need attention as well as the defect itself. In addition, such a child may have any of the health problems of other children which may be unrelated to his defect. Not uncommonly a mother who has been securing periodic health supervision for a normal child will discontinue this when a chronic disease or other problem requires repeated visits to a specialist. The excuse that the care of the specific problem required too much time and attention is understandable but unfortunate if it leads to neglect of other aspects of total health as, for example, neglect of dental care. The pediatrician can be most helpful in coordinating the long range treatment of a disease or defect with the long range consideration of the needs and best interests of the child concerned from the broad standpoint of health.

Growth and Development Principles

General Human Pattern.—Now I propose to discuss a few principles derived from studies of growth and development, which I believe deserve consideration in providing care for children. First, there is a general human pattern for all aspects of growth and development, many of which are easily recognized and the manifestations of which can be followed in individual children. Childhood is characterized by constant changes in a great variety of ways, and the changes which will occur in any one period are broadly predictable. For the pediatrician, these changes are encompassed by the words growth, development and adaptation. These processes progress according to general expectancies at each stage of development, and the pediatrician must know, in general, what to expect of children at each stage. We know that diseases manifest themselves in different ways with different mortality and morbidity rates at different ages, but the processes of adaptation apply to many other aspects of a child's health than the characteristics of illnesses. These differences with age stem from several basic features of childhood. The child is small, but constantly is growing, though at different rates at

successive periods, until in each aspect he has reached mature size. Of course, these differences in growth rates affect nutritional needs and other health problems. The child is immature, but is continually progressing toward greater maturity in different ways and to different extents at successive ages, so that at any one age, the liabilities of his immaturity are different from those of others.

Some age problems stem from the fact that the child is ignorant and inexperienced, but he is constantly learning and getting experience. He actually learns through the normal everyday experiences of life. As Dr. Wolfe pointed out, if he does not get the satisfactions required from these experiences, whether it be for love or physical activity or anything else, he will not progress satisfactorily in this learning or become more competent to deal with himself. Of course, as he gets older he learns both through natural experiences and through more formal education. The stages of learning which he has passed through and the opportunities for experiences which he has had affect the likelihood of accidents and many other aspects of his well-being.

We can say definitely that there is law and order and predictability in the progress of the child toward maturity; that natural laws determine in the main the changes which occur in the child with time, and that these occur in expected sequences. Certainly, before undertaking to provide care or give guidance for children, the pediatrician must know these general expectancies. Physical growth is characterized by constant forward progress, coming to an end in different parts at different ages. In this respect few latent periods or retrogressive changes occur. In contrast, mental, emotional and social development seem to manifest periods of latency and retrogressive change, and appear to be less ordered in progress.

INDIVIDUAL DIFFERENCES IN NORMAL CHILDREN.—The second principle of growth and development which we all recognize is that within the broad frame of progress made by all normal children, there are wide individual differences in each and every aspect. The pediatrician particularly must be familiar with the ways in which, and the extent to which, normal individuals differ between themselves, age by age. If it were not for these individual differences, we could give all mothers specific instructions and otherwise follow standard practices for children of any given age. Unfortunately, something like this approach is being attempted by some today through the various channels of mass communication. It is important to accept not only the principle that there is a wide range of individual differences between children at every age, but that these differences have an important bearing upon nutritional and other health needs—in fact, upon every aspect of child care. This concept stresses the importance of recognition of a child's individuality in respect to growth, development and adaptation in order to give advice and counsel appropriate for him.

The characteristics of the distributions for many attributes have been described for each age and sex, based upon population studies. So-called "norms" are available to serve as standards of reference for evaluating individual children. Such norms are useful in following the progress of a child and in helping to recognize when he is failing to maintain expected progress. Norms are unfortunately thought of as means of distinguishing normality from abnormality. This misconception, I think, comes from the use of a statistical word which has no such connotation. Norms only point to abnormality in the extreme when it usually is recognizable otherwise. Norms used as standards of reference make it possible to recognize some of the basic characteristics of a child and help to define how unusual he is in various attributes. For example, if a child's weight is at the third percentile, we can say that he is exceptionally light for his age because not more than three children in 100 would be expected to weigh so little. If his height is also at the third percentile, we can say that he is an exceptionally small child but with an appropriate weight for height. If his weight is at the third percentile but his height at the fiftieth percentile, we would recognize that the weight was unusually light for a child of average height and would seek for an explanation in build, small muscles, lack of fat, or other factors. This search might lead to the conclusion that the child is quite normal with an appropriate height-weight relationship for him on the basis of his genetic characteristics. On the other hand, it might suggest that there probably are some dietary or environmental factors which have been operative and account in some measure for his light weight, and these would be sought.

The physician is tremendously aided in his attempt to evaluate individual differences when he has repeated contacts and suitable records at appropriate intervals, for these permit him to rec-

ognize whether or not the child has been making expected or consistent progress. In general, consistent progress is more likely to result from constitutional factors whereas abrupt or pronounced changes in the course of progress suggest careful search for environmental causes which may deserve attention.

Self Likeness at Successive Ages.—A third principle in respect to growth and development is that a child tends to be like himself at successive ages. This characteristic is obviously because what he is like is so largely determined by his genes. The child who has inherited a weak potential for growth and a linear build will tend to have small gains in height and weight year after year, and will always, in health or illness, appear thin and small in comparison with another child endowed with a vigorous growth pattern and with potential for stocky bones and heavy muscles. Under conditions of chronic ill health or consistently inadequate nutrition, the latter may resemble the former in size and build. In a single screening examination, unaccompanied by adequate history, the basic differences between the two may be overlooked and both be classified as representing faulty growth or nutrition.

This principle provides a most important reason for following the growth and development of children periodically. It points up the advantage in evaluating a child's status by comparing him with his former self and not solely with his age group. The question which can be answered with more assurance in the former than the latter comparison is whether or not he is making consistent progress according to expectancy for him. Deviations from expected progress do not necessarily indicate disease, faulty nutrition, or other abnormality. When they are sudden and pronounced, however, they are much more likely to represent the results of environmental factors than unique individuality in respect to normal progress. Both methods of comparison have independent values and should be carried out whenever possible, notably as in the pediatrician's office. Comparison of a child with his peers in respect to age, race and sex reveals status and points out clearly his general attributes and any unusual characteristics. Comparison with his former self reveals aspects of progress and change. Both sets of information have value for the physician who is attempting to individualize his advice from the standpoint of total health. I wish to avoid the implication that change with time, as, for example, cross channel progress on a percentile growth chart, is necessarily an indication of abnormality. The natural development of a pronounced type of build and a change of pace when the adolescent cycle of growth begins, are common aspects of genetically determined progress. Sudden and pronounced changes, however, in direction and speed of progress deserve careful consideration and usually warrant search for environmental, dietary and not infrequently psychologic causes.

A few slides were shown at the end of this lecture to demonstrate the usual consistency in progress of growth in children with widely different characteristics of size, build and speed of maturation. For this purpose, percentile graphs were used for height, weight, and amount of fat and of muscle tissue. Also, a chart with skeletal age in the hand plotted against chronologic age was used to indicate individual consistencies but interpersonal differences in the speed of skeletal maturation. It was pointed out that the latter characteristic is highly correlated with the age of onset of the rapid growth of adolescence and with menarche in girls and secondary sex character development in both sexes. Examples of unique or deviate patterns of individual progress were also shown.

The cases used in these demonstrations and in a series of more detailed case studies presented at two subsequent sessions were selected from a series of about 135 children followed by the speaker and his associates from birth to 18 years under a series of periodic interviews and examinations. This research was broad in the scope of studies made and included much information about the family background, course of pregnancy, labor and delivery, dietary habits of mother, infant and child, social and psychologic factors operative at successive ages, illness experiences, and the like.

This project has been operating over the past 26 years at the Harvard School of Public Health under the general title of "Longitudinal Studies of Child Health and Development."

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VOLUME XLIV
NUMBER 11

The Pulmonary Manifestations of Hodgkin's Disease

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Hodgkin's disease, one of a group of diseases classified as lymphoma, may have protean manifestations not only producing generalized symptoms such as fever, weakness, malaise, and loss in weight, but also involving practically any tissue of the body. The clinical picture which one most commonly associates with this disease is lymphadenopathy, especially in the cervical region, which early in the disease may or may not be associated with constitutional symptoms. In addition, there has been noted involvement of the skin, bones, intestinal tract, liver, spleen, pancreas, adrenals, nasopharynx, muscles, central nervous system, pericardium, gallbladder, thyroid, tonsil, and genitourinary organs. In fact, any organ in the body containing lymphoid elements may be affected. Pulmonary manifestations are the special problem of interest in this report.

In an extensive review of Hodgkin's disease in 1948, Hoster, Dratman, Carver and Rolnick[1] stated: "The lungs may be the primary site of the disease. In the great majority of reported cases, however, the pulmonary lesions are said to be secondary to spread from other foci, directly from mediastinal nodes or from more distant sites by way of lymphatics or blood stream. It has been postulated that the lesions vary according to their mode of spread; if they result from direct extension, they originate near the hila and extend fanwise through the lobe of a lung. If brought by the lymphatic stream, the lesions spread along peribronchial and interlobar lymphatics; and if the route is hematogenous, discrete nodules may be found scattered throughout the lungs."

Peirce, Jacox and Hildreth[2] correlated the clinical and radiologic findings of 198 cases of Hodgkin's disease. In 37.4 per cent of these cases the chest was normal, and in 37.9 per cent there was mediastinal or hilar glandular involvement, in 13.6 per cent infiltration of the parenchyma of the lung, and in 11 per cent pleural involvement.

In a larger series, Vieta and Craver[3] noted pulmonary infiltrations in 38.5 per cent of the cases, isolated nodules in the lungs in 5.3 per cent, and pleural effusion in 15.8 per cent. Reports, however, range from only 16 cases of pulmonary involvement in a series of 340 cases reported by Castex, Pavlovsky and Valotta[4] to Moolten's nine out of 18 cases coming to autopsy.[5]

Jackson and Parker[6] found that 20 per cent of patients with Hodgkin's granuloma showing pulmonary involvement have pleurisy with effusion. Paterson and Paterson[7] stated that involvement of the lung is usually associated with pleural effusion. The purpose of this report is to direct attention to the frequency of intrathoracic manifestations of Hodgkin's disease other than the ordinary mediastinal and hilar adenopathies and their prognostic significance.

The most frequent symptoms produced by pulmonary involvement are not distinctive from other pulmonary disease, being dyspnea, cough, fever, wheezing, aching chest pain, pleuritic pain, and sputum. We encountered no cases in which hemoptysis was present. In several of our cases, however, the patient was asymptomatic when the pulmonary lesions were first noted, only to have symptoms develop subsequently.

As the symptoms are not distinctive, the roentgenologic findings are extremely variable. Many types of lesions have been described, including radiating strands of peribronchial infiltration, fine or coarse disseminated masses with ill-defined edges, massive pneumonic infiltrations with or without atelectasis, large round nodules resembling metastases, miliary dissemination, tracheoesophageal fistulas, pleurisy with effusion, segmental atelectasis, cavitation, endobronchial tumors, and numerous other types.

The frequency of a mediastinal mass or discrete hilar nodes in this disease is well recognized. This type of process is similar to the adenopathy of the superficial nodes. A less frequently noted intrathoracic manifestation is involvement of the pulmonary parenchyma and pleura.

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Lymphoid tissue is abundant in the lung, being most prevalent along a peribronchial distribution, especially at the points of bifurcation of the bronchi. Lymphoid tissue is also found in the perivascular connective tissue while the subpleural area is relatively devoid of it. The collections of lymphoid tissue in the lungs are just as susceptible as lymphoid tissue elsewhere to the etiologic factor that causes Hodgkin's disease.

At Duke Hospital, we reviewed 44 cases of Hodgkin's disease with roentgen evidence of pulmonary parenchymal disease or of pleural effusion. The cases were all proved pathologically, and only those with complete records available for study were used. Perhaps the relative proportion of pleural and parenchymal cases is not true as many of our older films were destroyed by fire. Cases were used only if their roentgenologic findings were unequivocally present. In four cases both pleural and parenchymal disease was present while in 22 there was pulmonary disease only and in 18 pleural effusion only.



Fig. 1. — Widespread nodular lesions throughout the lung fields, probably from hematogenous dissemination.

Classification

Instead of using purely descriptive terms, we prefer to follow Hoster's line of thought and divide our classification into three main categories with subcategories for the parenchymal disease classified by the mode of extension:

1. Pleural involvement, which usually manifests itself by pleural effusion. This is rarely bloody.

2. Endobronchial lesions, which secondarily may also produce tracheoesophageal fistulas, atelectasis, or emphysema. Hurd[8] and Vieta and Carver[3] reported bronchoscopic biopsies of ulcerated plaques revealing Hodgkin's disease.

3. Pulmonary parenchymal lesions.

a. Hematogenous dissemination producing diffusely scattered nodules or a miliary type of spread (figs. 1 and 2).

b. Lymphogenous spread resulting in linear or feathery densities corresponding to the distribution of the peribronchial lymphatics (figs. 3 and 4).

c. Direct contiguity from a pre-existing focus of involvement in mediastinal or hilar nodes with direct involvement of variable segments or lobes of the lung. These often give the impression of having broken through the retaining wall of lymph node and directly invading the lung (fig. 5).

d. Wessler and Greene[9] also described primary involvement of lymphatic collections in the lungs. Estimates of the frequency of this primary type of lesion have ranged from common to extremely rare.

Kirklin and Hefke[10] found 12 of 40 cases of Hodgkin's disease with pulmonary involvement, but in only one of these were enlarged mediastinal or hilar nodes lacking. Peirce, Jacox, and Hild-



Fig. 2. — Scattered nodules bilaterally with central cavitation of several of the nodules.

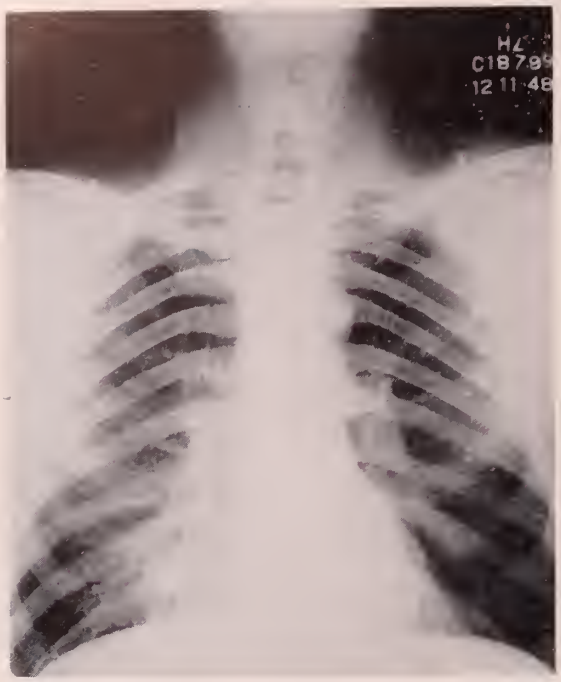


Fig. 3.—Fine feathery lymphogenous spread to right lower lung field.



Fig. 4. — More diffuse bilateral lymphogenous spread.

reth,[2] however, found 20 per cent of their cases of parenchymal disease without obvious node involvement. It is difficult of correlation roentgenologically, however, as the involved nodes may be too small to be visualized. In all of our cases with nodular involvement, this feature appeared to be related to the generalized involvement as in none of these could we prove that the Hodgkin's disease was limited strictly to the lung.

We encountered several cases of lobar atelectasis of the lung in our study, but it was thought better to omit this category from our classification on the grounds that this does not represent primarily intrinsic disease of the lung but only the secondary effect from the mediastinal and hilar nodes. Endobronchial lesions may also cause atelectasis; these rare cases should be included under category 2. Moolten[5] recorded a case which at autopsy showed a massive polypoid endobronchial mass to be the cause of atelectasis.

Table 1 shows the relative occurrence of the different types in our cases.

Table 1. — Pulmonary Manifestations in a Series of 44 Cases of Hodgkin's Disease

1.	Pleural	22
2.	Endobronchial	0
3.	Parenchymal	26
	a. Hematogenous	5
	b. Lymphogenous	17
	c. Direct contiguity	4
	d. Primary in lung	0

Discussion

The results of the study of our series of cases are summarized in table 2. Of the 44 cases, only three occurred in Negroes. This represents a significantly low figure in comparison to the general white-Negro ratio of patients seen at Duke Hospital. Some authors maintain that there is no

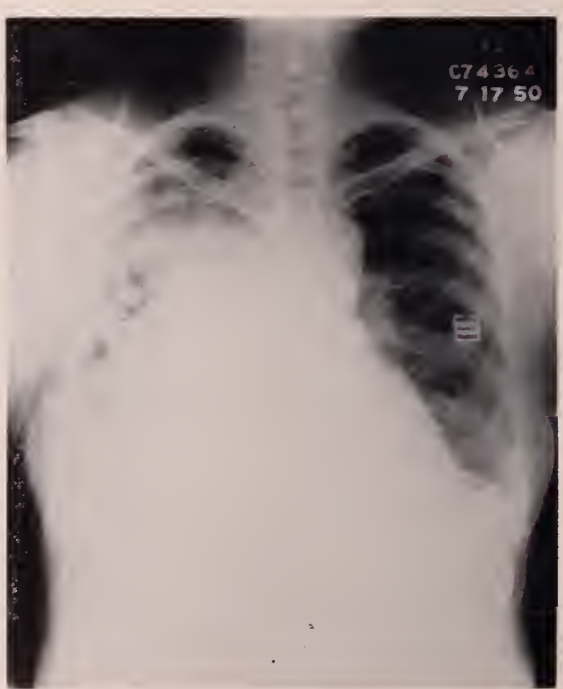


Fig. 5. — Large tumor mass in right lung field due to direct extension from hilar nodes.

Table 2. — Analysis of Series of 44 Cases

	Pulmonary	Pleural	Both*
White	24	21	41
Negro	2	1	3
Male	13	16	26
Female	13	6	18
Oldest	62	64	
Youngest	3	5	
Average age	32	33	32
Average months between Hodgkin's disease and pulmonary lesions	23.8	29.5	27.2
Average months between pulmonary lesions and death.	20.3	4.7	12.5

*Four patients had both pulmonary disease and massive pleural effusion.

essential difference in the incidence among races, but others assert the disease is definitely less common among Negroes. In a study of the cancer incidence in Birmingham, Ala., Marcus[11] found the incidence of Hodgkin's disease to be one and one-half times greater in whites than in Negroes.

The sex distribution in the patients having pulmonary disease was about even, but pleural effusion developed in only six women as contrasted to 16 men. This is more in accord with the accepted 2:1 or 3:1 male-female ratio in Hodgkin's disease.

The ages recorded were for the patients at the time of onset of the pulmonary disease, not at the onset of the Hodgkin's disease. It is noteworthy that the average age of the pulmonary and pleural groups was essentially the same, being 32 and 33 years respectively. Our oldest patient was 64 years of age, the youngest three years. This range confirms the general impression that Hodgkin's disease predominantly affects persons of early and middle adult life, but childhood and old age are not exempt.

Invasion of the lung may occur at any time during the course of the disease or at any age. Jackson and Parker[6] demonstrated the appearance of pulmonary lesions as early as one month after the apparent onset of the disease and as late as 12 years afterward. It must be remembered, however, that unless frequent roentgenograms of the chest are obtained during the course of the disease, it is difficult to judge the onset as these lesions may cause only minimal symptoms at first, which could be overshadowed by the generalized symptoms or by the symptoms due to the enlarged mediastinal nodes. In our cases, we dated the onset of the Hodgkin's disease to the time in the history of the appearance of enlarged nodes or to the onset of symptoms unquestionably due to Hodgkin's disease. The onset of the pulmonary manifestation was timed with the first roentgenogram giving positive evidence and not by symptoms. There was a wide variation in the relative time between the onset of disease and the pulmonary and pleural involvement, ranging from a case of pleural effusion in which the initial manifestation was an acute pleuritic syndrome to one in which the disease had been present 93 months prior to pulmonary findings. The average time elapsed before parenchymal disease started was 23.8 months while that for pleural effusion was 29.5 months.

The extreme variability of the period of survival of patients with Hodgkin's disease is widely recognized. Jackson and Parker[6] related prognosis to histologic subgroups designated as Hodgkin's paragranuloma, Hodgkin's granuloma, and Hodgkin's sarcoma, the last being the most malignant. To those who believe this concept, this might seem a logical way of explaining differences in survival of various patients. In general, it is thought that the development of pulmonary lesions is evidence of a more aggressive disease, a fact which further darkens the prognosis. Hoster and his associates[1] listed pulmonary parenchymal involvement as a factor associated with a poor prognosis.

Our results do not seem to substantiate the finding that pulmonary parenchymal disease in itself is an ominous sign; instead, they indicate that it is merely another manifestation of dissemination of the disease. It is no more serious a sign than involvement of bone or generalized adenopathy. We believe that the factors of most importance in patients either with or without pulmonary manifestations are the presence of constitutional symptoms, such as fever, chills, anorexia, loss in weight, and weakness, and also the extent of the generalized dissemination of the disease. In several of our cases the patient was relatively asymptomatic when first seen and usually had a survival time after the onset of the pulmonary disease of one to three years with one patient surviving as long as 85 months. The average period of survival for our patients after the onset of parenchymal disease was 20.3 months.

The onset of a recognizable pleural effusion, however, was found to be an extremely poor prognostic sign as the average length of survival after its onset was 4.7 months in the cases followed to death. There were two cases of pleural effusion not followed to death, the first in a patient with involvement of the wall of the chest

and the ribs on the same side as the effusion. This patient received considerable roentgen therapy over this region with gross disappearance of the involvement of the wall of the chest and of the pleural effusion. This case probably represents a pleural effusion secondary to the disease in the wall of the chest with only localized reaction and not generalized pleural involvement. When last seen, this patient had survived 141 months after the discovery of the pleural effusion and was still in good condition. In the other case, the patient has been followed for 18 months and is in fair condition on chlorambucil.

The exceptional sensitiveness of lymphocytes to ionizing radiation was established by many early experiments. When the entire body of an animal is exposed to irradiation, the spleen, lymph nodes, thymus, bone marrow, and even the lymph follicles of the intestinal tract show a more or less pronounced destruction of the lymphocytes, and the degree of destruction is proportional to the roentgen ray dose. This is well correlated with the usual accepted clinical knowledge of the good initial response of Hodgkin's tissue to roentgen rays.

In treating intrathoracic Hodgkin's disease Desjardins[12] preferred irradiation generated by moderate voltage rather than the 200 to 250 kv that is usually used. Earlier, Desjardins, Habein and Watkins[13] reported a rapid response of lesions of the lung to irradiation and at times they used a therapeutic trial of roentgen rays in aiding in the differential diagnosis of Hodgkin's infiltrate and tuberculosis. Later, however, Desjardins[12] indicated "that the radiosensitivity of pulmonary lesions in Hodgkin's disease is distinctly less than that of the peripheral and mediastinal foci. Nevertheless, the effectiveness of radiation therapy in achieving a notable regression of pulmonary disease in a significant percentage of cases is incontestable."

Scheinmel, Roswit and Lawrence[14] noted instances of favorable response in a majority of the types classified, with the exception of the lymphogenous type of dissemination. They found, however, no logical means for predicting the response of a specific lesion to therapy. Wolpaw, Higley and Hauser[15] recommended a dose of at least 1,000 r of deep roentgen therapy to each of the anterior and posterior portals in pulmonary involvement and they observed two cases in which good temporary regression occurred. Jackson and Parker[6] not infrequently noted that mediastinal masses entirely disappeared with irradiation while the parenchymal lesions remained relatively unchanged. Cantril[16] found x-radiation ineffective and observed that chemotherapy at times will give no more than a transitory regression without any lasting benefit. He suggested the possible use of radioactive gold or chromic phosphate in reducing the pleural effusion in these cases.

Our experience in treating Hodgkin's effusion and parenchymal disease has been that irradiation therapy over the pulmonary lesions has not been satisfactory. The usual treatment was around 600 to 800 r tumor dose. With the smaller doses the process frequently recurred. These same findings were noted in patients treated with chemotherapy. The danger of intensive irradiation is that of pulmonary fibrosis, which occurred in two of our cases.

Conclusion

In such a small series of cases, any analysis in regard to therapy of the pulmonary lesions is of little value. One fact seems consistent, however, that when pulmonary manifestations appear, the prognosis is not good because there is usually widespread systemic involvement.

It was difficult to determine in all cases whether the pulmonary lesions might be lymphogenous, hematogenous, or a direct extension of the disease.

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Puerperal Breast Abscess

Report of a Small Epidemic

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This report describes an outbreak of staphylococcal puerperal breast abscess among the women delivered at a military hospital of medium size having a large obstetric service. The United States Army Hospital at Fort Bragg, N. C., is rated as a 325 bed general hospital. Three thousand and four women were delivered on its obstetric service during the calendar year 1956.

Among the 1,843 women delivered during the first eight months of 1956, nine were treated by the surgical service for puerperal breast abscess. This number amounted to slightly more than one case per month for a usual incidence of 0.5 per cent. In all of these cases the abscess was caused by Staphylococcus aureus organisms showing considerable heterogeneity.

Of the 1,161 women delivered during the last four months of 1956, 36 were treated surgically for puerperal breast abscess, averaging nine cases per month for an incidence of 3.1 per cent. Only one of the 215 women delivered during January 1957 required such treatment, suggesting a return to the usual incidence. It is too early to comment on February, but by the third week in March only one of these 171 women had been treated for breast abscess. In all of these cases the abscess was caused by Staph. aureus organisms showing great homogeneity.[1]

When the importance of this problem became apparent in October 1956, the usual measures were taken to eliminate sources of infection within the hospital. Although several cases of staphylococcal furunculosis and nasopharyngeal infection among the obstetric personnel were eliminated, general sanitation improved and proper breast care emphasized, these measures yielded no apparent benefit. During the same time, a great many other infections caused by the same organism were seen in the clinics among persons who had had no contact with the hospital or its personnel. It was slowly accepted that the offending organism must be widely disseminated among the population served as well as prevalent within the hospital.

An incomplete study of the first part of the epidemic disclosed that all of the patients had breast-fed their children and suggested that the trauma of nursing in the presence of a virulent organism may be a precipitating factor for the susceptible puerperal breast. Accordingly, breast feeding was increasingly discouraged from the first of December on. It is estimated that, as a result, breast feeding fell from its usual level of about 50 per cent to less than 5 per cent during December, and remained at this new low level for the period covered in this report. Allowing for the onset lag, this decrease was followed by what appeared to be a most gratifying decline in the incidence of puerperal breast abscess, even though the high incidence of other Staph. aureus infections continued unabated. The final study showed that only eight of the 37 mothers in the epidemic group denied nursing. Of these, at least two were lactating at the time of treatment, and two others had used a breast pump. Information is lacking on one case. In the one case in which delivery took place in January 1957, the patient had nursed against advice.

The following table demonstrates the epidemic nature of the outbreak and the assumed beneficial effect of the reduction in breast feeding started in December.

It was the impression of the staff that this simple measure was largely responsible for reducing the incidence to nonepidemic proportions.

In the epidemic group of 37 patients the lesion was characterized by great homogeneity, both clinically and bacteriologically. Twenty-eight, or 75 per cent, had nursed for an average of 15.3 days, varying between two and 59 days. The average age was 23 years. Nineteen had right-sided involvement, 15 left, and three bilateral, for a total of 40 abscesses. There were six recurrences. The initial onset of symptoms varied between seven and 84 days with an average of 18.9 days. Incision and drainage were carried out an average of 10.2 days after onset, varying between one and 32 days. Surgery for recurrence in the same or other breast followed by as much as 75 days. Thirty-one of the patients were hospitalized

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Breast Abscess Patients by Month of Delivery

1956 Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	1957 Jan.	Totals
0	0	3	5	1	0	0	0	11	8	10	7	1	46
												Epidemic	37

for an average of 6.4 days, varying between three and 13 days, and followed in the clinic for an average of 22.3 days. Six were treated solely as outpatients for an average of 27 days. The total duration of surgical care averaged 28.4 days each for 35 patients.

All of the initial culture specimens grew Staph. aureus in pure culture. All were hemolytic. All but one were coagulase-positive among the 36 tested. All but one fermented mannite, and all were salt mannite resistant when tested (23 cases).

Antibiotic sensitivities were determined on all of these cultures using standard impregnated paper rings manufactured by National Bio-Test, Inc., and containing 1.5 units of penicillin, 1 mcg. of erythromycin, 10 mcg. each of streptomycin, Terramycin, tetracycline and Aureomycin, and 500 mcg. of triple sulfonamide. All but one were found sensitive to Chloromycetin. Twelve were resistant to erythromycin. Only three each were sensitive to streptomycin and Terramycin. One was sensitive to penicillin and one to Aureomycin. None were sensitive to triple sulfonamide or tetracycline. In two instances subsequent cultures showed the development of resistance to erythromycin following therapeutic use of this drug. Sixteen cultures were further tested for sensitivity to 30 mcg. of Albamycin, five to a like amount of carbomycin, and nine to 2 mcg. of Matromycin. All of these proved sensitive.[2]

Treatment

Typically, these patients first presented themselves at the postnatal clinic with unilateral or bilateral mastitis. Nonsurgical treatment including an effective antibiotic, usually Chloromycetin, cured an estimated one third. Only in those, however, who were started on effective antibiotic therapy very early in the disease, probably within the first three days and before suppuration had occurred, could the process be thus aborted. In the remainder, the lesion progressed to obvious abscess formation despite such therapy.

Among those with abscesses, there was little apparent difference in severity between those who had been treated and those who had not been treated. The rapidly progressive, extensive, invasive abscesses with many loculations involving multiple lobules were slower to heal and caused more tissue destruction than the slowly developing, small, well demarcated, unilocular abscesses, but this difference correlated poorly with antibiotic preparation and seemed far more a matter of individual host response. Likewise, following surgical drainage, antibiotic therapy with erythromycin or Chloromycetin had little effect on either the course of the particular abscess or the development of subsequent abscesses. In short, once a purulent process had developed, the only curative treatment was surgical drainage with antibiosis contributing but little assistance.

Inadequate surgery, usually due to too small an incision or not opening into all the loculations, especially when performed under inadequate local anesthesia, led to chronicity and multiple surgery. It was found best to work under general anesthesia, make sure that all indurated areas were broken into by digital exploration, insert sizable unfilled Penrose drains into all the major extensions, leave the drains in place for several days to insure adequate sinus formation, and keep the sinuses patent as long as necessary, preferably by gloved finger. Where feasible, periareolar or submammary incisions were preferred to radial incisions for their superior cosmetic results. Warm saline compresses were of help in keeping the sinuses patent, and many of the patients reported that they gave excellent symptomatic relief.

During this same period, eight newborn infants were treated surgically for breast abscess. Two of these were patients in the hospital at the same time as were their mothers for puerperal breast abscess. Culture and sensitivity reports in these cases were, for all intent and purpose, identical with those in the puerperal cases.

Summary

An epidemic of puerperal breast abscess is reported and its clinical aspects discussed.

The prevalence of a virulent organism among the population served, rather than contagion within the hospital, is thought to have been the primary cause.

The suspension of breast feeding is believed to have been instrumental in curtailing the outbreak.

Staphylococcus aureus was grown in pure culture in all cases, showed little variation from case to case, and was uniformly resistant to most antibiotics.

Despite in vitro sensitivity to some antibiotics, these had little effect on the course of the disease once suppuration had developed. An effective antibiotic, if given early, may arrest the antecedent mastitis.

The treatment of puerperal breast abscess consists primarily of surgical drainage. Other measures are of adjuvant aid.

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Asthma and Hay Fever Versus Spells Of Asthma and Hay Fever

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During my practice of allergy, to the treatment of which disease I have confined myself exclusively for the past 22 years, my figures show that a new patient has seen or been under treatment by an average of five other doctors, and consequently has had a lot of advice with which I do not agree. Add to this the lay information, misinformation and the patient's own conclusions or convictions and one can easily see the difficulties I encounter.

There are a great many ideas presented with which I do not agree, but the most common ones can be boiled down to four or five, namely, and I quote: "I never get asthma unless I get a cold," "Gases, smoke and any odors cause my asthma," "This or that food causes my asthma," "A change in weather, a cold spell, always causes me to have a spell," "My trouble is caused by dampness," "I have a sinus condition," and "Antibiotics cure some of my spells of asthma."

"Colds"

Let me take these causes one by one and discuss them. The first and most frequent is "I get a cold and then asthma." Since the most common manifestations of allergic shock are on the part of the nose, chest and skin and since in the majority of cases the nose is affected first, one must look upon the "colds" with a suspicious eye.

In taking an allergic history one finds that in the majority of cases the nose showed the first symptoms. Patients have allergic rhinitis or hay fever before they have allergic bronchitis. The nose may have given them trouble for many years before the asthma starts. Sometimes the period is short, but it is rather rare to have a patient in whom the asthma started first. If the doctor will and can dig out these nasal symptoms, he will find striking differences between them and those of an acute coryza.

The average patient will describe all the classical symptoms of an allergic rhinitis, but still calls it a "cold." If such patients have it in the summer, they are more inclined to call it hay fever for the idea that hay fever can affect them in winter has not as yet been accepted. So I hear about "colds" lasting for an hour to many months.

Since the advent of antihistamines the picture is further confused. These patients take some antihistamines, and the "cold" is checked. Now since colds seem to be due to bacteria or virus organisms and allergic rhinitis is due to a sensitivity to a nonbacterial or nonviral material, I do not believe any one drug is going to be beneficial to troubles both of infectious and noninfectious origin.

Also, colds seem to be contagious; they run through a whole family. Allergic rhinitis is not contagious, although since it is frequently a familial affair, the same condition producing trouble in one member of a family may do so in another member. It looks like one "caught it from the other," thereby in the lay mind clinching the conviction that the trouble in question is contagious.

Few people will take this explanation. Even when, after months of treatment of their allergy,

one succeeds in stopping their nasal symptoms, they still report that the treatment has stopped their "frequent or continuous colds."

Careful experiments tend to show that an actual "acute coryza" produces an immunity of from three to four months. There is no reason to assume that an allergic person may not contract an acute coryza, but from my experience I believe that in the big majority of the cases of this type allergic rhinitis is followed by allergic bronchitis and not "colds followed by asthma."

Odors, Chemical Gases and Smoke

The second point is "odors, chemical gases and smoke cause asthma." I believe that this again is a mistake. Asthma and hay fever, in my opinion, are basically allergic in origin. I do think, however, that a distinction should be made between asthma and hay fever and a spell of asthma or hay fever. By that I mean that many allergic persons may remain under their allergic tolerance point for varying periods of time and consequently have no symptoms. In a spell, a combination of allergy plus an irritant may cause an attack which otherwise would not happen.

I classify an irritant as any substance which, when contacted, will cause an irritation in at least 90 per cent of all persons. An allergen I classify as a substance which, when inhaled or swallowed, will cause trouble only in persons termed allergic, about 7 to 9 per cent of the people. Thus a normal individual and an allergic one are subject to dust on the road or elsewhere. Each will experience some irritation of the nasal and bronchial mucous membrane, but the trouble is transient and only bothersome to the normal person. In the allergic one there is added to the swelling from the allergy the normal swelling from the irritant, and thus the two cause a complete stoppage of the nose or bronchioles.

One cannot treat for outside dust or chemical fumes. Avoidance, both for the normal and allergic person, is the only method left. The same reasoning holds for infections, usually chronic, and for emotional factors. They do not cause asthma or hay fever, but they can and do precipitate a spell of either or both. A history of attacks may lead one to determine that an irritant, infection or emotion may be the predominant factor, or, in others, one may deduce that the allergen was the big factor and the irritant was of little importance.

Until a differentiation between allergens and irritants and between asthma and hay fever and spells of asthma and hay fever is made, one can frequently make an error in treatment as well as diagnosis.

Foods

Now I come to the foods "which cause my asthma." It is held by the majority of allergists at the present time that the foods are minor elements in allergy in adults but most important in children. Since this idea is relatively recent, it is not a common belief. There are few adults in whom I think that certain foods are big factors, but these will show upon testing with the proper material, and, I repeat, I find they are rather rare. But when trying to explain this view to a patient, one runs up against the widespread convictions and food phobias engendered in the public by lay articles, television and radio advertisements and the comments of friends. That the emotion of fear or indecision regarding foods can and does enter the picture and cause the trouble and that it is not the foods is the most difficult thing I encounter to explain to patients. Nearly all of them are convinced that because "it happens every time I eat that food," it is conclusive evidence to them that it is the food, and rarely can one shake that conviction even in the face of a negative test.

Having been faced with this reasoning so many times, I look upon the terms "gastrointestinal allergy" with a rather dim eye, particularly in adults.

Weather Changes and Dampness

"Changes in weather and dampness cause asthma." Mainly, this statement is true. A sudden cold spell will throw many persons into temporary spells of asthma and hay fever. This is particularly true of the first cold spell and in decreasing degree during the following ones. Why this happens or what changes take place in the body which precipitate this trouble I do not know, nor do I know anyone who does. It is one of the unsolved problems in this disease of allergy. Dampness, that is, an increase in relative humidity, I do not believe is a cause, although it is amongst the most numerous things to which people ascribe their spells. With dampness comes chill, and I believe it is the chilling of the body and not the humidity which is to blame.

Let us consider a well known combination, croup and the croup kettle. Now croup is an allergic manifestation. A croup kettle, with or without medication, would raise the relative humidity in the room above 80 per cent and yet it

does relieve this spasm. Why then would a high humidity help one allergic condition and make another one worse? I do not think it does.

Now into this picture of change in temperature a large emotional element enters. This I proved to my own satisfaction by the following procedures. I took 14 patients who, while sitting in my office, asked me to turn off my air conditioner. I allowed them to sit in my outer offices, which are not air-conditioned, while being tested for from two to four hours. I noted the temperature out there. It was 82 degrees. I brought them into my office. The air conditioner was going on Fan. The temperature in the office was 82. Thirteen out of these 14 patients had spells of asthma and hay fever within five minutes.

Sinus Condition

"I have a sinus condition." At least nine out of 10 who tell me this have made their own diagnosis, or it has been made by a doctor without a transillumination or roentgen examination. They go on to describe a case of hay fever without a single symptom which leads me to suspect a sinusitis.

Antibiotics

Now I come to the use and abuse of antibiotics. Antibiotics should be used only in the presence of an infection. With an infection there is usually an elevation of temperature, aching and a changed blood picture. As I have said previously, such a condition often acts as a complicating or predominant element in spells of asthma and hay fever, and in such cases their use is definitely indicated. Antibiotics, however, do not affect allergens, and when the spell ceases during their use, it simply means that the infection was the big factor in said spell, but unless this fact is recognized, the next asthmatic patient gets antibiotics even though he has no infection. The first I consider good use of antibiotics; in the latter cases, it is misuse.

Ragweed and grass pollens, animal epidermals and house dust are allergens, and they are not affected by antibiotics. In cases in which they are the sole or principal causes of the spells, antibiotics should not be used.

Multiple "Allergies"

One frequently hears that a person has "two or three allergies," and this nomenclature is gaining ground. Allergy, the basic disease, is singular. The manifestations or the organs which allergy affects may be multiple, and the things to which they are sensitized, namely, allergens, may be numerous, but there is no such thing as allergies. One might just as well speak of a person having typhoid fevers.

My purpose in writing this paper is not to present something new, but rather to emphasize some well known facts and put a slightly different interpretation upon them.

916 Citizens Building.

Dr. O. W. Hyman Is President's Guest At Eighty-Fourth Annual Convention

Dr. O. W. Hyman, of Memphis, Vice President of the University of Tennessee in charge of Medical Units, is the guest of Dr. William C. Roberts, President of the Florida Medical Association, for the Eighty-Fourth Annual Convention of the Association.

The Convention begins Sunday, May 11, and ends Wednesday, May 14. It is being held in the Americana Hotel at Bal Harbour.

Dr. Hyman will address the General Session Monday morning at 10:40 on the subject "The Greatest Problem of Medical Education and Its Relation to Medical Practice."

Volume XLIV
Number 11

Neuromuscular Reflex Therapy for Spastic Disorders

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PHILADELPHIA

Physicians are all aware of the swiftly changing concepts that characterize our modern world of science. Strangely enough, neurology, one of our basic medical sciences, has lagged behind its fellow specialties for lack of a dynamic therapy to equal its symptomatic accuracy and its precisional diagnostic screening.

A Withering Neurology

There are many who deplore the present trend toward virtual extinction of the organic neurologist. In the recent past, much mixed patient material has passed through the diagnostic screening clinics of the well trained neurologists. Therapy and treatment have become secondary to diagnosis and classification. A static state of clinical neurology has developed, dependent upon a few drugs such as potassium iodide, the bromides and Salvarsan, and even fewer physical measures of benefit, such as hydrotherapy, massage and the "rest cure."

In the early nineteen thirties, a change began to appear in the then already stagnant field of psychiatry; Freudian analysis gained partial recognition. Metrazol, electric shock, carbon dioxide and lobotomy stirred the members of the neuropsychiatric specialty and raised the dust from the bones of many a revered authority, to sweep forward into a clearer concept of mental disease and establish a variety of dynamic therapies, now directed toward the solution of a host of collateral aspects, as well as to the problems surrounding "the mental state" and its response or behavior to the social structure of a modern civilization.

About the same time there came about an increase in the number of neurosurgeons, offering better methods of visualization of the nervous system through ventriculography and pneumoencephalography, along with instrumentation, skills and technics for relief and correction of many organic lesions of the brain and spinal cord. This direct and dynamic attack upon the acute and subacute organic aspects of the neurologic field weaned away a large number of patients who formerly languished for lack of active therapeutic consideration by the organic neurologist.

The diagnostic art of neurology became replaced by the mechanical processes of the operating room, the laboratory and the x-ray department.

With the functional and organic clinical material fading from his practice, the organic neurologist was forced to turn to the ever present syphilitic, neuritic and chronic "gremlin" diseases, only to find the dermatologist and chemotherapist had successfully treated and appropriated the syphilitic group and the druggists and the cults, the neuritic group while lay organizations were dictating the methods of treatment for the "cerebral palsied," the multiple sclerotic, the dystrophic, the dyskinetic and retarded groups, formerly classed as "hopeless," and so long subjected to the fate of the leper and the outcast of only a few decades ago. The psychiatrist now has rightfully laid claim to this long-neglected group.

The neurologists who had been trained in the mathematically exact science of organic diagnostic screening have only themselves to blame for their smug complacency and the lack of a more dynamic therapy. The distractions produced by the neurophysiologist and the experimental laboratory, in seeking the answers to vital dynamic function and the "why" of the nervous system, became a welcome contrast to the static features of fixed microscopic tissue pathology after death. This drama of experimental research became so fascinating that it overshadowed the purpose and the life objectives for which the nervous system was created, and the need for a rational and corrective therapy to meet its demand.

The patient desired an answer for his handicap, rather than a name or explanation as to the functional disturbance of his parts.

The satisfaction of making a difficult diagnosis overshadowed the importance of successful treatment. The describing and recording of a new "reflex," if by chance one had been overlooked by the many other eager searchers before, guaranteed immortality to the individual whose name would then be placed upon it—"the back-

Read before the Florida Society of Neurology and Psychiatry, Annual Meeting, Hollywood, May 5, 1957.

door to a neurological Valhalla," Dr. Chas. K. Mills used to call it. This feat or the discussion of curious combinations of symptom complexes became more absorbing than developing therapeutic measures of relief, and almost completely dominated the programs and meetings of the past. A dynamic therapy for neurologic disease was almost unthinkable.

Meanwhile, the patient, a suffering or handicapped human being, after being properly labeled, was mentally catalogued along with former similar specimens along the walls of the laboratory, given a palliative program and advised to "try this and that" type of therapy.

A Dynamic New Therapy

Into this static, reactionary and self-satisfied atmosphere of withering neurology has recently come a new and dynamic form of therapy. True, it may be "too little and too late," as the trend today is to combine some other more active specialty with neurology, such as neuropsychiatry, neurosurgery, neuropediatrics and neuro-opthalmology, recognizing the basic value of neurology, but finding only a diagnostic or descriptive use for it from a practical therapeutic point of view.

To the "die hards" and the reactionaries of the Classic Age, a "reflex" is a "reflex," and its purpose is measured in terms of its present day usefulness, such as drawing up the leg when you step on a tack (reaction of defense), or pulling a quadrant of the abdomen to the side, when you scratch around the umbilicus. The purpose of this latter movement is not quite clear, but "that is what happens in most people unless they have multiple sclerosis, are too fat, or have been pregnant."

Thinking usually becomes a little nebulous at this point, and even more so when you ask: "What is the purpose of the Babinski sign?" This sign is the dorsal flexion of the great toe with fanning of the other toes upon proper superficial stimulation of the outer half of the plantar area and is critical in the area supplied by the first sacral nerve. The reply is something like the following:

"This pathological reflex tells you there is organic trouble with the upper motor neuron or pyramidal tract."

The question is again: "What is the 'purpose' of the Babinski reflex? It cannot be 'pathological' because every normal human and primate infant demonstrates it at birth."

The usual answer to this repeated question varies from a long extemporaneous or ingenious attempt to explain, "Why a Babinski," to a curt "So what?" John Fulton, after many years of experimental analysis of this interesting phenomenon, gave me this adroit answer: "I never did think much of the Babinski reflex anyhow."

Those of the older school who still worship at the throne of "the brain," considering it the source of all man's activities (as the Greeks worshipped the many gods and disciplines on Mt. Olympus), are puzzled to explain a fact known to every farmer's child. That fact is that after the neck and body of the chicken or turkey has been separated from the head and brain, on the old chopping block of course, there arises in the victim for several minutes a strong dynamic activity with movements throughout various parts of the body, wings and legs, rather than a sudden total paralysis after losing its head.

True it is that the violent spontaneous movements are "purposeless," jerky and sometimes convulsive in character, without the need for a brain; but nevertheless, movements they surely are, whether of simple local reflex type, highly integrated flapping, hopping and postural mechanisms, or aimless gyrations which continue until loss of function and death come to, of all things, the spinal cord.

Men have thoughtlessly watched this well known response throughout the ages without grasping its significance and potentials, as they have also looked upon the horizon of a supposedly flat world, in which the sun "sets" or "goes down," refusing to look beyond the illusion into the true facts regarding the phenomenon. As you know, the truth of the matter actually reverses the concept without altering the situation. A moving upward of a horizon, on the rim of a rotating globe, finally obliterates the relatively fixed sun as the source of light. It appears as though the "sun had set," when in fact it is a "horizon rise."

Within the past few years a similar and complete reversal of concept has arisen, without alteration of established detail, to overthrow our old neurologic beliefs regarding the function of the brain and spinal cord. We have come to view the "brain organ" as the child of the spinal cord, developing through an evolutionary period extending over 600,000,000 years of vertebrate elaboration, and not the spinal cord as just the loyal servant and messenger of a capricious brain master. One must pause long enough to think this through.

Those who can stand on a clear evening and watch the "horizon rise," rather than the "sun go down," are ready to grasp the significance and possibilities of a reversal of concept that underlies the new dynamic therapy which has recently been developing. This therapy aids the neurologist in dealing with chronic and formerly so-called "hopeless" groups of spastic patients, both during the problems of infancy and childhood and in the later years of life, when central nervous system injury and "strokes" become the common cause of spastic types of affliction.

When it became evident that powerful and even highly integrated movements and muscle responses can be obtained with an intact spinal cord, without the need of the brain, the question naturally arose some 15 years ago: "Could we train these isolated uncontrolled or spontaneous spinal, bulbar and reflex mechanisms?" Was it possible to arouse in the background of a patient who had so-called "paralysis" of spastic type, due to injury or loss of higher cortical areas, function from the remaining semiautomatic or automatic units at the uninvolved more primitive levels? If control and response from the cortex were lacking, yet the spinal cord was still willing and able to respond to proper reflex stimuli, acting directly upon the less skilled centers below, could a purposeful "conditioning" of an integrated postural reflex movement be established, using the Pavlov principle of repeated activation?

The postural reflexes (tonic neck, righting, vestibular, ocular and others) are already highly organized for primitive purpose and semiautomatic function. They bear the same relationship to the simple tendon reflex as calculus does to arithmetic.

The determination to teach and train these mute units of the central nervous system, rather than the conscious levels of the spastic patient's brain, has produced some remarkable clinical results.

It is at this point that the static "sun set" group of neurologists departs, with the traditional disbelief of the brain worshiper in anything but robot automatism as the purpose and function of the spinal cord. Here the modern dynamic trend in neuromuscular reflex therapy takes over. It points out that spastic paralysis is the loss of the ability to control voluntarily the release and modification of power and movement, and not, therefore, a true paralysis such as polio which involves the loss of both power and movement. The power and movement can be demonstrated to be present in the spastic patient by various sensory modalities of posture, pain and the superficial or deep perceptive senses. It is the proper initiation, modification, control and skilled application of the power release, not power production, to the muscles of the spastic patient, which now chiefly concern the clinical therapist. Most spastic patients are not weak in the involved muscle groups, as hyperreflexia will easily demonstrate. They do not lack power; they lack control and the proper release of power.

The therapeutic measures of the past to exercise the muscles in order to make them "strong" is all right for the polio victim but not for the spastic patient. The spastic patient already has too much power and too little control.

With this concept established, the therapeutic attack on the spastic forms of paralysis moves directly toward the problem of not how to make the patient stronger or more powerful, when he already manifests violent responses to superficial and deep tendon reflex responses, but how to modify, subdue and integrate the crude power which is present, thanks to the brain stem and spinal cord, and convert it into some purposeful skill. A clinical axiom follows: The greater the primitive power, the less the skill (control), and vice versa.

It has been apparent in the true spastic hemiplegic or paraplegic patient that "the harder the patient tries," little or no effect on responsive movement follows in the afflicted part. This is the old concept that the "power" resides in the brain cortex, to be dispensed from that level by "the will" in desired degree.

Since the power supply does not exist at the higher levels of the brain organ, but in the primitive and ancient brain stem and spinal cord, the efforts to "produce" or "make a movement" are naturally of no avail. You might as well expect two professional chess players to run through the University of Miami football team for a touchdown as to call on the brain organ itself for a power display.

The crude, primitive power "patterns of movement," as integrated reflex responses, will be found in such activities as the homolateral amphibian crawling mechanism or the homologous extremity response seen in the frog style of swimming response. These complicated activities are semiautomatic and well under the control of

the postural reflexes (tonic neck, ocular, vestibular, righting and others) provided the higher levels of the cortex are out of suppressive control.

Relaxation and re-education of the spastic patient through lower level reflex activity, by removal of partial interference and stubborn suppressive block from an injured or defective cortical area (hemispherectomy) permit uninvolved control areas to release coordinated power to a spastic unresponsive part. Thereby, more active participation is made possible in simple purposeful power activities, required for such activities as walking, feeding and self care.

The skilled and refined movements of the hands, fingers and feet are localized close to the upper brain levels and are the most recent evolutionary additions to the vertebrate nervous system, as displayed by man. Such skills suffer most, or are irrevocably lost, when cortical areas are injured or destroyed. The ancient activities, however, of the Amphibian, Reptilian and Mammalian eras persist in the form of whole or partial postural and defense reflex responses at lower levels which have lost their original "purpose" in the primate and man. They may, however, become appropriately aroused to be valuable again, for such activities as walking, balance and crude postural and feeding responses, when disaster overtakes the higher and more recent levels of the brain.

Diagnosis

The first and most important step before selecting a program of therapy is to be sure of the patient's diagnosis, which of course entails a careful neurologic examination and screening.

It is equally important to establish that a true spastic type of paralysis exists, whether slight or severe, if neuromuscular reflex methods of therapy are to be utilized.

A spastic patient must manifest one or more of the following signs and symptoms to be classified as such:

1. The stretch reflex (increased resistance to stretch, followed by sudden "clasp-knife" release)
2. Hyperreflexia
3. So-called pathologic reflexes:
 (a) Hoffman sign
 (b) Babinski sign
 (c) Others
4. Clonus (ankle, wrist, patellar)
5. Weakness or loss of movement to voluntary effort

Care must be taken to *rule out rigidity*. "Cogwheel" or "lead pipe" types are easily recognized as the extremity is stretched; the resistance is usually maintained throughout the range of passive movement. There is no sudden release, and in pure types the reflex and so-called "pathologic" signs are absent. Contracture deformity, immobility due to pain, fixation of joints and other local or peripheral causes may account for loss of active movement and simulate paralysis.

Once it is established that a true spastic type of paralysis exists in some form, it becomes obvious that the lesion must be situated at or above the tenth thoracic segment of the cord, because gross involvement of the lumbosacral area below this level of the cord produces flaccid paralysis in the lower extremities, without the Babinski reflex, clonus, or reflex hyperactivity. Bladder signs are usually present, along with muscle atrophy and a tendency toward decubitus. With spastic paralysis established, we may now determine if neuromuscular reflex therapy is advisable.

Highlights of Progress

I shall only touch upon the highlights of the progress that has been made in developing this more dynamic type of therapy during the past 15 years. They may offer to you certain practical measures for the benefit of your patients that we can now recommend.

Valuable therapeutic measures for "unlocking" spastic contraction and the utilization of "reflex" movements arose from our studies to determine the original purpose of a human reflex. Strange as certain reflexes may seem, they appear to us today to be uselessly attached to the super activities of the present glorified human nervous system. Nevertheless, after tracing them back to their primitive origin during the evolution of the central nervous system, we find that they apparently once were of great importance to forms of life and development through which the vertebrate types have transcended and emerged at various "ages" during the past 400,000,000 years. The structures (fins) of the water forms (fish) eventually began to solve the problems of land and air (amphibians) through the development of extremities with paddles (reptilian), wings and feet. This required approximately 200,000,000 years, during which time the vertebrate forms that did not acquire the most favorable adaptation did not survive to carry on the gain.

I spoke of the so-called "Babinski reflex" which is present at birth when the human infant

emerges from the uterine waters of its mother, to take its first breath of air, representing an independent (amphibian) and lung-breathing type.

Slow motion picture studies of the swimming frog show that the purpose of the "Babinski reflex" to the frog is to respond automatically when the surface of the hind foot contacts a solid object on the floor of the tank (scratch along the sole of the foot) so that its toes fan to grasp the surface, or to be ready to "take off" with the largest webbed area of application against the surface that is possible. The "purpose" today is only as a curiosity to the public or a "pathologic sign" to the neurologist, whereas 300,000,000 years ago it was a necessity to propulsion, and still is, for those forms of amphibious life that must survive in liquid surroundings.

As this "reflex action" persists independently of higher functional levels above the lower thoracic level of the cord, its mechanism is intrinsic to the lumbosacral area. When propulsion of the mammal type (walking) develops, it becomes "controlled" by function of higher levels to be "released" again as an independent activity when some disturbance removes the higher facilities of integration. We may say that the patient "drops back" to a lower evolutionary pattern of function. If we are to arouse and utilize such activity, we must attempt to reproduce the posture and the purpose for which it was designed.

The practical point is this: with organic spinal cord or brain lesions situated above the tenth thoracic level (umbilicus as a skin sensory dermatomere localization), and associated with spastic paralysis of the lower extremities, *repeatedly* producing the Babinski reflex gives active movement and exercise, reflexly, to the patient's muscles and joints concerned with intrinsic movements of the toes, dorsal flexion of the foot, and flexion and extension of the leg. These responses are most important while one is teaching a hemiplegic patient to regain a more normal pattern of walking, and these spinal cord responses are of great value in reducing the contraction of the calf muscles and heel cord, thus preventing ultimate contracture. Contracture, once established, can be corrected only by stretch or orthopedic measures of relief.

It is a simple undertaking to produce the "Babinski" response a hundred times by repeatedly stroking the bottom of a spastic foot. One should use a toothbrush or object that will not scratch or irritate the skin.

The remarkable result from repeating this procedure (100 strokes) twice or three times a day for two weeks is that the Babinski sign frequently disappears spontaneously; the response is no longer confined to the toes and foot, but by the repeating of this local activity, other muscles and joints partake in a more integrated and purposeful act such as dorsal flexion of the foot and withdrawal of the leg, which flexes upward on the abdomen. This is a movement which is similar to that normally used in walking, in climbing stairs, or in a "steppage gait." All of this arose spontaneously from the simple Babinski maneuver. The central nervous system tends to organize its "reflex" units for a purposeful expression of motor function.

In many instances, if this spastically paralyzed patient voluntarily tries to make the effort of "drawing up the leg" ("central reinforcement") at the moment the stimulus is applied, he may learn to augment, influence or even *"capture the reflex."* Thus, with practice and proper coordination of movements from the upper extremities, he may learn a more primitive "pattern of walking," which, though not normal for the human, is far better than the typical "dragging of the foot" and stiff leg gait so common to this type of hemiplegia.

The results in "capturing" a few of the more simple reflex mechanisms require the accuracy and persistence of practice, as one learns to play chords on a piano. The spastic hemiplegic patient with severe cortical loss can be taught to walk again with or without a cane.

As long as one hemisphere of the brain remains in good function, and there is no fixation of joints or contracture of muscles (assuming the spastic reflex mechanisms are present and intact in the paralyzed part) the normal remaining brain can be taught to regulate the lower centers of both sides in a greatly improved manner.

Although nothing new has been added to function at the cortical level, and no regeneration of lost brain or cord cells is possible, nevertheless the patient feels improved, and a change of morale usually follows. As better function appears with the reflex semiautomatic responses under partial control, a change from a "hopeless" to hopeful attitude ensues.

The danger is that with the limited benefits of improvement possible by "capturing" remaining responses from lower and more primitive centers, the patient may come to expect more

progress than is possible to attain, and hence become discouraged and disappointed that "full" recovery is not possible. It is the old story of the beggar who asks for more, when much has already been received. The possibilities and limits of this intrinsic therapy should be carefully explained in advance.

With this dynamic neuromuscular reflex approach to the problem merely suggested and outlined, it becomes obvious, if we choose to try to fit the prehistoric mosaic of reflex activities into a carefully planned matrix of desired response, that the problem of rehabilitation for the spastic patient is no longer one of paralysis. Instead, it becomes one of lack of skill and control of the crude spinal cord power and highly integrated reflexes still available.

When "ankle clonus," for instance, is encouraged and sustained two to four hours a day by a simple device called a "clonometer," there is appreciable improvement in the size, power and response of the calf muscles which, later on, instead of manifesting "atrophy of disuse," may be of real value to the patient, should spontaneous recovery from a partial "stroke" be possible.

The repeated use of the "Marie-Foix" or "withdrawal" or "defense" (postural) reflex is most dramatic. This is obtained by sharply flexing the toes at the metatarsal joint, which causes withdrawal of the leg and relaxes adductor spasm (scissors gait), and reduces spasticity even in the highly spastic paraplegic patient. It has been of value all the way from the slight but gratifying relaxation in the severe spinal case (to permit a urinal between the thighs) to the recovery of the ability, in the hemiplegic patient, to lift the leg in going up steps, after "capture" of this reflex.

Other useful reflexes and their "unlocking" postural components have been described in detail elsewhere. One more example, however, of this newer dynamic approach to the spastic problem concerns the fingers, hands and upper extremities so important to feeding and self care.

In a true spastic hemiplegia the thumb is drawn into the palm of the hand and the fingers enclose it, so that the hand is useless. The first step is to open or "unlock" the spastic hand. This release is accomplished by a simple postural reflex procedure. Place the patient face down, head turned away from the paralyzed spastic hand. Draw the hand and arm downward and backward until the back of the hand rests on the buttocks. With a little manipulation, if no pain, contracture or ankylosis is present, even a long time useless hand will open and the fingers relax in extension.

The next phase of the procedure to capture a a finger movement is to undertake a number of hours of passive movements of the fingers and thumb to restore muscle-joint freedom and sensory perceptive awakening of the postural possibilities.

Because the head is turned away from the hand in this position, the patient cannot watch or assist in the results; two mirrors should be adjusted in order to enable him to see his fingers, which are behind him. Then, ask him to try to assist as a finger, the middle finger at first, and the thumb are approximated passively, or reinforced by using the Hoffman reflex (snapping the tip of the middle or ring finger); he may, in many instances, "capture" the movement and, with practice, learn to control it. Later, the hand may be placed shoulder high in front of the seated patient and "feeding movements" established by special digital apparatus devised for this purpose.

Amphibian (homolateral) and Reptilian (crossed) patterns of crawling and extremity coordination lead to better balance and control of the hemiplegic side.

The measures outlined are part of a large number of dynamic intrinsic mechanisms, which are reflex or automatic, but, like the exercises of arithmetic, underlie the more complicated mathematical computations, primitive movements underlie later learned skills. These "reflexes" and patterns are now being employed to develop crawling, walking, feeding and coordinating mechanisms required in basic progression, by utilizing the older unskilled primitive centers of the nervous system in the brain and spinal cord to aid, when the higher levels of control at the cortical or midbrain levels have been partly or severely involved.

As in all other medical problems of long term nature, cooperation, a favorable mental attitude of helpfulness and persistent practice and patience are required to regain a loss that may otherwise never become re-established.

The psychiatrist has found, within the functions of the brain itself, a means of helpful therapy, as developed by Freud and his followers. The neurologist may find through the intrinsic and simple, as well as the highly organized, neuromuscular reflex mechanisms (that he has so long described but studiously ignored), the clue to many helpful features that can assist a patient to

express a wider degree of function and independence in the modern aspects of rehabilitation.

Summary

This new dynamic field of therapy is open to those whose eyes view the world as a round and moving horizon, instead of a flat senseless shelf. In the newer concept of neurology, the brain organ is no longer the old piano player beating out and forcing an acquired movement, the volume of which is dependent on the power of his fingers. Instead, now in the newer light, it becomes an *organ* player, whose delicate touch releases the patterns of power and combinations of muscle response to lower control areas, which, if skillfully blended, give the same symphony in either case.

The former concept has given rise to the hopeless prediction that as the power at the brain source is gone, no movement can be expected, and hence no rational therapy is available. The present and more modern concept is that great but crude power potentials exist in the lower centers of the brain stem and spinal cord. In the spastic patient these may be trained through their remaining reflex commands and control areas, which respond when properly addressed in terms of these more primitive centers, which understand the signals of posture, joint, tendon, pain and skin senses, rather than the voluntary selections of the will.

Even if we may know and recognize all of this, as we do a rotating earth and a satellite era, there will be those who will still prefer to see the "sun set" and a spastic paralysis continue as a fixed and hopeless state.

Here on the beaches of Florida, where some of the old world were first to touch the new, history repeats itself, and suddenly the opportunity to exploit a vast new clinical field of neurologic potentials has opened for those who dare to explore its possibilities. The neurologist has found his "Acres of Diamonds" at last, upon his own doorstep, and in the patient's bulbospinal reflex mechanism.

7404 Elbow Lane, 19.

Four Guest Speakers to Appear On General Session Program of Convention

Four guest speakers are to appear on the program of the General Session of the Eighty-Fourth Annual Convention of the Florida Medical Association which begins Sunday, May 11, at Bal Harbour in the Americana Hotel. In addition, Dr. O. W. Hyman, of Memphis, Tenn., the guest of President William C. Roberts, is scheduled for an address.

The other guest speakers include Dr. David B. Allman, Atlantic City, President of the American Medical Association; Dr. David M. Hume, Richmond, Va.; Dr. David T. Smith, Durham, N. C., and Dr. J. Rocher Chappell, Orlando.

The Hospital Program in Florida

Alvin D. James
Jacksonville

The past year has been one of intense work in developing Florida's first hospital care program for its medically indigent citizens. The Act of the 1955 legislature, establishing the new program, Hospital Service for the Indigent, provided that it become effective Jan. 1, 1956. In lieu of the $3,000,000 requested for the operation of the program, $500,000 was appropriated. It appeared to be the thinking of the legislature that this reduced initial appropriation would be sufficient to establish the administration of the program and to provide operational experience, looking forward to adequate financing by the 1957 legislature. Although only one sixth of the original requested appropriation was made available, the administering state agency, the Florida State Board of Health, was successful in implementing the program in 24 of the 67 counties. During this first year, Jan. 1, 1956 to Dec. 31, 1956, one third of the counties representing 35 per cent of the state population elected to participate. With Dade County coming in the program effective Jan. 1, 1957, the program is presently effective for 54 per cent of the state's population.

Through past working experience in initiating the program, it is evident that more county participation would have been attained if sufficient state-matching funds had been made available. Because of the small amount of state funds involved, only 24 counties elected to establish hospital care programs for their medically indigent under the provisions of this law. For the 24 counties that elected to participate, however, there were sufficient state monies to provide 20 cents per capita to each participating county. For this coming biennium, July 1, 1957 to June 30, 1959, it is expected that the budget request for $4,000,000 will be appropriated by the current session of the legislature, thereby making available sufficient state-matching funds on the basis of the original recommended need for at least 50 cents per capita. With the expectation of having available an adequate amount in state funds for the program, statewide participation can be expected.

To comment further regarding the future development of the hospital care program administered by the State Board of Health, both the Senate and House Appropriation Bills have been approved providing $4,000,000 for a single program: Hospital Service for the Indigent. With this appropriation grant, it is expected that the objectives set forth by Chapter 401, Hospital Service for the Indigent can be and will be accomplished.

The July 1956 special session of the legislature adopted a resolution authorizing the State Welfare Department to utilize certain unencumbered state funds together with federal matching funds to establish the Public Assistance Medical Service Fund, or what is more commonly referred to as the Hospital Care Program for Public Assistance Recipients. From this fund, the State Welfare Department is authorized to provide hospital services for recipients of state welfare grants in accordance with the provisions of the 1955 Act, Hospital Service for the Indigent. Thus the State Board of Health and its affiliated county health departments became responsible for the medical administration of the program initiated October 1 by the State Welfare Department, which provides hospital care for public assistance recipients. Statistical data and operational experience reveal that approximately one third of all the medically indigent citizens of Florida are public assistance recipients; therefore, the State Welfare Department's program is meeting approximately one third of the total need in all counties of the state. This expense is presently paid for entirely by federal and state funds and does not require county-matching funds.

Because the State Welfare Department's program for the categorically indigent and the State Board of Health's program for the medically indigent are both administered under the provisions of the same state statute, it was believed to be possible to present a single program to the hospitals and physicians of the state, using identical forms and regulations. With the objective of having both state departments proceed with common administrative policies, the respective Medical Advisory Committee to each state department was combined into a single joint advisory committee to consider problems common to both programs. Although much has been accomplished by

Hospital Consultant, Florida State Board of Health.
Read before the Florida Health Officers' Society, Hollywood, May 5, 1957.

this combined effort, it is evident that the medical administration has not developed as was originally prescribed.

Statistical Résumé

There follows a résumé of statistical data summarizing the activities of the hospital care programs administered by the State Department of Public Welfare and the State Board of Health and its affiliated county health departments. The activity data are representative of the three programs: Hospital Service for the Medically Indigent, Hospital Care for Public Assistance Recipients, and the Cancer Control Program.

A statement of appreciation is extended to the responsible representatives of the State Department of Public Welfare and the Blue Cross Association for their cooperation in making possible the compilation of the following statistical data:

Summary

In summarizing the activities of the three programs:

1. There were 6,454 hospital admissions financed in whole or in part by the three programs:

3,361—Hospital Service for the Medically Indigent

872—Hospital Care for Public Assistance Recipients (2 mos.)

2,221—Cancer Control Program

2. A total of 57,260 patient days were reported for the 6,454 admissions, giving an average length of stay of 8.9 days.

3. A total of $919,664.74 was expended for the programs for an average cost of $142.49 per admission. This expenditure is not indicative of actual cost for hospital services provided because of involvement of third party contributions, payments made by insurance companies, and the arbitrary establishment of per diem rate of reimbursement.

4. Ninety-seven different hospitals were utilized in providing hospital care for certified indigent patients.

5. A comparative analysis of the Indigent Hospitalization Programs for the states of Florida and Tennessee, which administers comparable programs, reveals the following:

	Fla.	Tenn.
Average length of stay	8.9	10.5
Average cost per admission	$142.49	$136.52
Average cost per day	$ 16.06	$ 13.06

Summary of Activities
Hospital Program for Indigents

(Jan. 1, 1956 through Dec. 31, 1956)

Program	Patients	Days of Hospital Care	Total Disbursements	Per Diem Cost	Average Patient Cost of Hospital Stay
HSI	3,361	33,320	$553,810.53	$16.62	$164.77
HCPAR (10/1/56 — 12/31/56)	872	7,057	129,369.21	18.33	148.35
CANCER	2,221	16,883	236,485.00	14.00	106.47
	6,454	57,260	$919,664.74	$16.06 Av.	$142.49 Av.

Comparative Analysis
Indigent Hospitalization Programs

	Florida	Tennessee
Average length of stay	8.9	10.5
Average cost per admission	$142.49	$136.52
Average cost per day	$ 16.06	$ 13.06

Estimate of Professional Services
Granted Gratuitously

	HSI	PAR	CANCER	TOTAL
Estimated professional fee	$226,901.11	$63,356.40	$248,796.42	$541,053.93
Estimated professional fee per patient	$67.51	$74.95	$112.02	$74.95 Av.

To comment briefly about the Cancer Program, both the Senate and House Appropriation Committees provide for the merging of this program with the Hospital Service for the Indigent Program, which carries an appropriation of $4,000,000 for the biennium. On the basis of this recommendation, it is planned that effective July 1, 1957, the Cancer Program, which is presently operating 19 tumor clinics located in 16 counties, become an integrated part of the Hospital Service for the Indigent Program, therefore requiring partial financing with county funds.

6. Inasmuch as neither of the programs provides for payment of professional services, a conservative estimate of physicians' services granted gratuitously amounts to more than a half million dollars. Based on a study made of representative cases for each program, the estimated value is presented thus:

Hospital Service for Medically Indigent	$226,901.11
Hospital Care for Public Assistance Recipients (First two months of operation)	65,346.40
Cancer Control	248,796.42
	$541,053.93

The value of physicians' services given "free" amounts to $74.95 per patient. Projecting this estimate on a yearly basis, the value of "free services" given by physicians of Florida would amount to several million dollars.

In behalf of the State Board of Health, a sincere expression of appreciation is extended to the membership of the Florida Medical Association for this most generous contribution to the health needs of the indigent citizens of Florida.

Conclusion

In concluding this report, I should like to emphasize that the State Board of Health has endeavored to administer the hospital care program for the medically indigent in accordance with the provisions of the authorizing statute; therefore, in so far as possible, the responsibility for making a professional determination regarding a patient's need for hospitalization has been left to the treating physicians and the county health officers.

Many meetings have been held during the year, over the state, to explain the purpose and objective of the state aid programs. Meetings have been held with medical societies, welfare boards, and hospital representatives in order to discuss any peculiar or particular administrative problem.

Considering the magnitude of such a program, it requires time and experience to put a program of this nature into operation. Admittedly, errors have occurred, but efforts have been made to profit by these mistakes. It is believed that a substantial foundation has been laid for a practical, conservative hospital care program for the indigent. This accomplishment is the result of some most significant assistance received from the appropriate committees of the Florida Medical Association and the excellent cooperation received from Florida physicians, health officers and hospitals. The State Board of Health appreciates receiving any constructive criticism that would be of assistance in the future development of the hospital care program.

Box 210.

Twelve Florida Physicians to Present Addresses At Scientific Assemblies of Annual Convention

Twelve physicians from Florida are scheduled to present addresses during the two Scientific Assemblies of the Eighty-Fourth Annual Convention of the Florida Medical Association which begins May 11 at Bal Harbour in the Americana Hotel.

The physicians include Drs. Abraham R. Hollender, Miami Beach; Nathan S. Rubin, Pensacola; Gerard H. Hilbert, Pensacola; David A. Newman, Palm Beach; Michael M. Gilbert, Miami; Robert G. Cushman, Jacksonville; Edward R. Woodward, Gainesville; Richard G. Connar, Tampa; George H. Hames, Lantana; William W. Stead, Gainesville; John G. Chesney, Miami, and Hawley H. Seiler, Tampa.

ABSTRACTS

Retroperitoneal Lymphatic Cyst (Cystic Lymphangioma). By Benedict R. Harrow. J. Urol. 77:82-89 (Jan.) 1957.

A case of retroperitoneal lymphatic cyst (cystic lymphangioma) is reported, bringing the total number in the English literature to 15. The relationship of this type of cyst to mesenteric, omental and other types of retroperitoneal cysts is presented. This paper stresses that the diagnosis of a lymphatic cyst depends mainly upon the histology of the wall of the cyst rather than upon the mere presence of chylous fluid. The urologist's participation in the diagnosis and treatment of retroperitoneal tumors is briefly reviewed.

Oligospermia: A Clinical Study of Treatment with Methylandrostenediol. By John M. Schultz, M.D. Fertil. & Steril. 7:523-539 (Nov.-Dec.) 1956.

The results of treatment with methylandrostenediol, a steroid with a close resemblance to methyltestosterone, given orally in 50 mg. doses for eight weeks to 24 infertile males with oligospermia and 5 azoospermic males, are here reported. In oligospermia, there was no significant improvement in spermatogenesis. The highest increased motility in both series was during the therapy phase. An absolute increase of 21 per cent in motility in pronounced oligospermia (16 cases) was observed, and an absolute increase of 0.8 per cent in motility in the higher subfertile group (8 cases) also was noted. Six pregnancies occurred (25 per cent). There was no improvement in nonobstructive azoospermia. Libido improved in 65 per cent of 29 patients treated.

The author concludes that methlyandrostenediol therapy in oligospermia has been followed by enough improvement, especially in motility, to warrant further clinical investigation. He warns, however, that methylandrostenediol is not extolled as a definitive therapy for oligospermia. Its indiscriminate and promiscuous use in every infertile male would undoubtedly yield the usual number of poor results in his opinion, and he adds that a larger number of patients must be observed over a longer period of time before the final results can be evaluated, with cases carefully selected, studied and adequately controlled with several semen examinations prior to the start of therapy.

The Fate of Patients Surviving Acute Myocardial Infarction: A Study of Clinical and Necropsy Data in Two Hundred Fifty Cases. By Richard W. P. Achor, M.D., William D. Futch, M.D., Howard B. Burchell, M.D., and Jesse E. Edwards, M.D. A. M. A. Arch. Int. Med. 98:162-174 (Aug.) 1956.

In seeking to learn what lies ahead for patients surviving an acute attack of myocardial infarction, the authors studied 250 hearts with gross myocardial scars indicative of healed infarction, selected from necropsies performed at the Mayo Clinic during the five year period 1946 through 1950, with special regard to the pathologic anatomy and its correlation with the clinical features. The cause of death was primarily cardiac in origin for nearly two thirds of the patients. The three major types of cardiac death were death from congestive heart failure, death from recurrent acute myocardial infarction, and "sudden death" without congestive failure or acute infarction. The last-mentioned mechanism was the commonest of the three and was infrequently associated with recent coronary thrombosis.

Antemortem diagnosis of a previous acute myocardial infarction was not made in nearly half of these patients. There appeared to be a definite relationship between the size of the scar indicating the extent of infarction of the ventricular wall on the one hand and the incidence of clinical recognition on the other. For those patients whose acute myocardial infarction was diagnosed clinically the average length of survival following recovery from the acute episode was 43 months, only 24 per cent surviving five years or more and 7 per cent 10 years or longer. The period of highest mortality was within the first year after the acute illness. From the standpoint of cardiac morphology and clinical features the patients surviving five years or longer did not differ significantly from those of the entire series. Hence, it was concluded that the subsequent course of patients who had survived an episode of acute myocardial infarction could not be accurately predicted on the basis of morphologic or clinical findings.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. Box 2411 Jacksonville, Florida

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What Price Radiation?

The recent emphasis on the fall-out of radioactive particles from nuclear weapons testing has produced almost hysterical outbursts in the press. Scientists have joined the outcry and have signed statements deploring the tests. These statements have been used politically both in this country and abroad. A calm, objective view is needed to evaluate medically the risk, not only of weapons tests, but of radiation from other sources.

Physicians have known of the dangers of radiation for many years. They have recognized, as well, the benefits to the patient from the intelligent use of radiation. Physicians are accustomed daily to taking calculated risks. Treatment of patients with any type of drug entails the danger of a reaction. Widely used drugs, such as digitalis and atropine, must be used in doses which approach toxic levels to obtain a therapeutic effect. Each operation has an irreducible risk attached to it. Regardless of the care with which the patient is prepared, patients will die as a result of the anesthetic or of the operative procedure itself. Physicians recognize that these risks can be reduced to statistical probability. When the doctor attempts to apply the statistics relating to probability to any individual case, the data no longer meet scientific criteria. The reasoning breaks down because of the inherent biologic variability of all living things. No two individuals will react identically under the same circumstances to the same hazard.

People all over the world are exposed continuously to all types of radiation. In Florida, physicians are familiar with the damage done both by the infrared rays of the sun and other sources of fire. Doctors treat the sunburn from overexposure both to the direct and reflected ultraviolet rays. The much coveted suntan is a reaction of the body to this potentially harmful radiation. The production of skin cancer as a result of prolonged overexposure has been called to the attention of physicians of the state through exhibits at the annual meeting.

Cosmic rays constantly bombard the population. These rays, from unknown sources in outer space, penetrate buildings and even can be detected deep in mines. Gamma radiation, given off from the earth and its products, constantly bom-

bards people. The intensity of the radiation varies considerably from one part of the country to another. Data are needed on the extent of background radiation in Florida, particularly since our phosphates contain uranium and rare earths. Our beach sands, roads, and even the sea which surrounds us give off radiation constantly. Modern Florida houses, which are largely constructed of masonry these days, give off more radiation than do the wooden houses formerly used much more in the South. In addition to the bombardment from external sources, people are continuously receiving small amounts of beta and gamma radiation from internal sources. The chief offender is the natural radioactive isotope of potassium which occurs in a definite proportion with the nonradioactive form in our food.

To these natural forms of radiation, other man-induced hazards are added. X-radiation is now widely used not only in medicine, but in industry. The direction of the primary ray can be anticipated and some wave-lengths filtered out without reducing the effectiveness of the beam. The scatter from x-radiation is more difficult to predict. Fluoroscopy utilizes a relatively large amount of penetrating x-radiation. The radiation of radio waves is used in diathermy, occasionally with harmful effects. Similar damage has been reported from close exposure to newer high intensity types of radar. Atomic explosions of either the fission or fusion variety produce further hazards which vary with the type of device and the height at which it is detonated. Those explosions close to the ground raise clouds of radioactive dust which rise into the stratosphere and increase the fall-out as the tiny particles circle the earth. Florida is relatively safe from this source of radiation since the prevailing winds tend to waft the clouds from the test sites in Nevada, Eniwetok, Australia and Siberia in a more northerly direction.

Why are the effects of radiation of such concern to the physician? We know that mutation is a normal biologic process which occurs naturally at a given rate. Some mutations are good, and we apply the result in agriculture to the development of new strains of plants and better breeds of animals. Some mutations are harmful. Fortunately, most harmful mutations result in death of the organism, but some are not lethal and are genetically transmitted. In man, more and more biochemical defects which can be transmitted, such as diabetes, pernicious anemia and phenylpyruvic oligophrenia are being seen. Radiation increases the rate of mutation, but it cannot be predicted whether the result will be good or bad.

In plants and animals, the harmful mutations can be discarded, but in man, they cannot. The somatic body cells can be harmed by all types of radiation. The burns of the skin and bowel from x-ray therapy are familiar to physicians. The apparent increase in the rate of leukemia in radiologists, as compared with other physicians and other men of similar age, has been the subject of recent inquiry. The data seem clear that the incidence of leukemia has increased above the predicted rate in the survivors of the atomic explosions at Nagasaki and Hiroshima.[1] How much radiation is involved in the production of leukemia in children is not yet clear. It is known that congenital defects can be produced by radiation of embryos early in pregnancy. In man, most harmful effects occur if the exposure takes place before the fourth month of the pregnancy. The reproductive cells of both men and women are harmed by radiation. The effects, however, may take several generations to become evident.[2,3] The physician must recognize and pinpoint the risks involved. He should accept these risks when the use of radiation is necessary in the care of his patient and must provide all possible protection against harmful effects to other parts of the body.

What should the physician do to reduce the harmful effects of radiation? Diagnostic x-ray procedures should be restricted to those necessary on the basis of clinical judgment. The recent action in curtailing programs of mass photoroentgen examinations of the chest for tuberculosis and the restriction of the technic to groups of high risk are sound measures which have been adopted at various places in Florida. For example, at the University of Florida, films will be taken only of those students who give positive reactions to tuberculin skin tests; this procedure will doubtless be adopted in other schools.

Elective x-ray examinations of the abdomen in women should be scheduled ideally for the two weeks immediately following the menstrual period. X-rays should not be taken early in pregnancy. If there is a pelvic disproportion and a film had not been taken before the pregnancy began, it would be wise to wait until the sixth or seventh month. Patients will readily accept this advice if the physician explains the reason. X-rays of children should be kept to a minimum, and the

pelvic region should be avoided as much as possible.[4] Fluoroscopic examination should be made only when the data needed cannot be obtained from films. Fluoroscopic examinations should be spaced at intervals, and the number of repeat examination, as of the gastrointestinal tract in peptic ulcer or colitis, should be kept to a minimum. All diagnostic radiographic equipment should be monitored regularly. Physicians have learned to wear protective aprons and gloves, but we could build better shielding for patients and technicians.

All radiation is cumulative in its harmful effects. It would be wise to have each person keep a personal health log in which medical information could be entered, especially the doses of radiation given by physicians. The safe doses are not known, and scientists are not in agreement, in spite of extensive research, on permissible cumulative amounts of radiation. The accurate measurement of an effective tissue dose of penetrating radiation is a technical problem which has not been adequately solved. It is not known what the relation of the cumulative doses of radiation from wave lengths, such as those produced by the sun and radio-generating equipment, is to that produced by gamma or x-rays. Plants concerned with nuclear energy, whether operated by the Atomic Energy Commission or private industry, have shown an excellent safety record in this country. Because Florida has no source of fossil fuels, atomic power will doubtless achieve greater use in the state in coming years. Power reactors will not explode. Safeguards for operating personnel are built in through proper engineering design. Waste disposal from reactors is a difficult problem, but in Florida the possibility of burial deep at sea offers a convenient and safe means for disposal of spent fuel elements.

In spite of the dramatic character of the dangers from nuclear materials, the greatest known hazards, at present, are those produced in the physician's own office.

1 Lewis, E. B.: Leukemia and Ionizing Radiation, Science 125:965-972 (May 17), 1957.
2. Glass, B.: The Genetic Hazards of Nuclear Radiations, Science 126:241-246 (Aug. 9) 1957.
3. Neel, J. V.: The Delayed Effects of Ionizing Radiation, J. A. M. A. 166:908-916 (Feb. 22) 1958.
4. Lincoln, T. A., and Gupton, E. D.: Radiation Dose to Gonads from Diagnostic X-ray Exposure, J. A. M. A. 166:233-239 (Jan. 18) 1958.

The Eighty-Fourth Annual Convention of the Florida Medical Association begins May 11 at the Americana Hotel at Bal Harbour. Final session is the Second Meeting of the House of Delegates, May 14.

Annual Graduate Short Course Discontinued

Held regularly for a quarter of a century, the Annual Graduate Short Course has this year been discontinued. This outstanding contribution to medical postgraduate education in the state has through the years been a June feature of wide appeal to members of the Florida Medical Association and has been sponsored by the Division of Postgraduate Education of the College of Medicine of the University of Florida in cooperation with the Association and the Florida State Board of Health. Announcement that it would no longer be held was made at a meeting of the Association's Committee on Medical Postgraduate Course held on March 16, 1958, in Jacksonville.

At this meeting Dr. William C. Thomas Jr., Director of the Division of Postgraduate Education of the College of Medicine of the University of Florida, outlined plans for two to three day courses, each in a particular basic field of medicine and directed at both the general practitioner and the specialist, to be scheduled approximately four times a year. Dr. George T. Harrell Jr., Dean of the College of Medicine of the University of Florida, announced that in addition to these formal short refresher courses at Gainesville, the College of Medicine will put on courses outside the school if there is sufficient demand. It will also be glad to co-sponsor graduate courses presented by recognized medical organizations provided the College of Medicine is permitted to help plan and supervise these courses.

Dr. Homer F. Marsh, Dean of the University of Miami School of Medicine, explained the several types of graduate courses offered locally by the School of Medicine and announced plans for a series of three day programs throughout the academic year, starting in October or November, to which any physican in the state would be welcome.

At the request of Dr. Turner Z. Cason, Chairman, the members of the Committee and Dr. Harrell, Dr. Thomas and Dr. Marsh discussed whether or not there is further need for the Committee and, if so, what its future functions should be. It was unanimously decided that the Committee should be continued and have the following functions: (1) Represent the Association in sponsoring postgraduate courses; (2) Offer advice and coordination to prevent duplication of effort; (3) Do a certain amount of investigation; (4) Publicize courses and encourage physicians to undertake

postgraduate courses. The Committee requested the Chairman to appear before the designated referral committee at the Association's annual meeting in Bal Harbour this month to present the consensus of the Committee and its recommendations.

Dr. Cason deserves the hearty commendation and genuine appreciation of the members of the Association for the able leadership he has given the Committee for more than 25 years, and the Association is fortunate to have his continued services in that capacity. His enthusiasm, persistence and vision in promoting the cause of graduate medical education in the state have resulted in an ever expanding program which is now assured on the highest level under the guidance of the state's two university medical schools. While many will miss the annual June Short Course, there is satisfaction in knowing that it yields to progress in the right direction.

American Medical Association Annual Meeting San Francisco, June 23-27

San Francisco will be host to some 12,000 to 15,000 physicians next month when the American Medical Association's 107th Annual Meeting is held there. The five days of June 23-27 will hold countless attractions, such as an outstanding scientific program of diversified lectures, panel discussions, scientific exhibits, motion pictures, televised surgical procedures and commercial exhibits. The convenient center for the Scientific and Technical Exhibits, motion pictures, color television and lectures will be the Civic Auditorium, the adjacent new Plaza Exhibit Hall and other surrounding buildings. The Sheraton-Palace Hotel will be the headquarters for the sessions of the House of Delegates.

Activities are scheduled to begin on Monday morning, June 23, with the Scientific Exhibit, color television, and motion pictures, together with the Technical Exposition. On Monday afternoon and Tuesday morning, general scientific meetings will be held. A symposium on the care of the severely injured patient will open the general scientific program on Monday afternoon, and Tuesday morning's general meeting will feature another symposium on hazards associated with therapeutic agents.

Formal scientific section meetings will begin on Tuesday afternoon and continue through Friday morning. Several sections will meet in buildings within easy walking distance of the Civic Auditorium. The Section on Ophthalmology and the Association for Research in Ophthalmology will meet in the Fairmont Hotel. All of the sections have arranged excellent programs with many panel discussions and symposiums as well as lectures. Subjects for special panel discussions and demonstrations include: perinatal problems; methods of resuscitation of infants; nutrition; physical examination of physicians, using electrocardiograms and chest x-rays; fresh tissue pathology, and treatment of fractures. The Section on Miscellaneous Topics also is planning sessions on allergy, prevention of traffic accidents, prevention of injury in sports, and medical professional liability. Other features will be a color television program of live operations and demonstrations from San Francisco Hospital and a varied motion picture program. Among the nearly 300 exhibits arranged by the various sections in the Scientific Exhibit there will be a group of exhibits on arthritis and a question and answer conference on nutrition.

Two high school winners of A. M. A. scientific awards at the National Science Fair will display their prize exhibits again this year. In addition, the top winners of the intern-resident and medical student exhibit classifications at the Student American Medical Association convention this spring will be invited for the first time to exhibit at an A. M. A. meeting.

Registration officially opens at the new Plaza Exhibit Hall on Monday, June 23, at 8:30 a. m. and closes Friday noon. Advance registrations will be accepted on Sunday, June 22, from 12 noon to 4:00 p. m. On Tuesday and Wednesday mornings the Scientific and Technical Exhibits will be open to A. M. A. physician-members only.

A postconvention attraction of interest to many members is the Hawaii Summer Medical Conference to be held in Honolulu on July 1-3,1958. Timed to follow immediately after the San Francisco meeting, the Conference is under the auspices of the Hawaii Medical Association, a constituent society of the A. M. A., which has extended an open invitation to Mainland physicians to attend. Included in the program are breakfast panels and a special afternoon clinic at a local hospital. Such outstanding speakers as Dr. Frederick C. Robbins of Cleveland, Dr. Ernest Jawetz of San Francisco and others of equal stature will present papers of particular note. Official travel arrangements to Hawaii to attend the Conference are under the direction of Lee Kirkland Travel, c/o Medical

Tours, P. O. Box 3433, Chicago 54, Ill. Aside from attendance at the scientific sessions, various other official social functions will be provided in the official trips, and a choice may be made of traveling round-trip by air or combining air and steamer travel between the Mainland and Honolulu.

Mount Sinai Hospital Postgraduate Seminar Miami Beach, May 22-25

"Recent Advances in Diagnosis and Therapy" is the theme chosen for the Eighth Annual Postgraduate Seminar to be sponsored May 22 through May 25, 1958, by the Mount Sinai Hospital of Greater Miami at the Deauville Hotel in Miami Beach. Seven distinguished lecturers will present two lectures each, and two symposiums will be featured, one on "Unusual Surgical Emergencies" and the other on "Critique of Recent Approaches to Heart Disease." This course is approved for Category I, American Academy of General Practice.

The faculty members and their subjects are: Dr. Herrman L. Blumgart, Professor of Medicine, Harvard Medical School, "Clinicopathological Correlation of the Coronary Circulation" and "Relationship of Thyroid to Heart Disease;" Dr. Frederick Fitzherbert Boyce, Professor of Clinical Surgery, Tulane University School of Medicine, "Improved Outlook of Carcinoma of Stomach" and "New Concepts in Surgery of Biliary Tract and Pancreas;" Dr. Dwight Harken, Associate Clinical Professor of Surgery, Harvard Medical School, "New Horizons in Heart Surgery" and "Surgery of Acquired Valvular Disease;" Dr. Robert M. Kark, Professor of Medicine, University of Illinois College of Medicine, "Clinical Value of Renal Biopsy" and "Disease Associated with Alcoholism," also a motion picture entitled "Medicine and Nutrition in Arab Kingdom of Libya;" Dr. Hans Popper, Director of Pathology, The Mount Sinai Hospital, New York, and Professor of Pathology, Columbia University, "Clinicopathological Correlation in Hepatitis" and "Pathways of the Formation of Hepatic Cirrhosis;" Dr. Steven O. Schwartz, Attending Hematologist, The Hektoen Institute for Medical Research of the Cook County Hospital, Chicago, "Present Concept of Pernicious Anemia and Pernicious Anemia-like Diseases" and "Value of Clinical Observation in the Diagnosis of Hematologic Diseases;" and Dr. Leroy D. Vandam, Clinical Professor of Anesthesia, Harvard Medical School, "Present Status of Hypothermia in Anesthesia and Surgery" and "Problems in Anesthesia for Patients with Heart Disease."

Florida Association of Blood Banks Annual Meeting Ponte Vedra Beach, June 7-9, 1958

The Twelfth Annual Meeting of the Florida Association of Blood Banks will be held at Ponte Vedra Beach on June 7, 8 and 9. The sessions will take place at the Ponte Vedra Inn, beginning on Friday night with the annual business meeting. The scientific session will open at 9:00 on Saturday morning, with Dr. Robert B. McIver, President of the Jacksonville Blood Bank, delivering the welcoming address. Two outstanding physicians from the blood bank field will then present the scientific program. The afternoon meeting, beginning at 2 p. m., will be an administrative session. The annual banquet will take place Saturday night at the Inn, with Dr. John T. Stage of Jacksonville serving as toastmaster. The Sunday morning session will be devoted to a workshop for technicians. Dr. James J. Griffitts of Miami and Dr. John B. Ross of Jacksonville will conduct the workshop.

Mountaintop Medical Assembly Waynesville, N. C., June 19-21

Of increasing interest to Florida physicians is the annual Mountaintop Medical Assembly, held at Waynesville, N. C. For the fifth successive year, it will be held this summer, the dates being June 19, 20 and 21. This course gives 15 hours of Category I credit to members of the American Academy of General Practice.

At the opening session on Thursday morning, three lectures are scheduled, to be followed by a question and answer period. Dr. Willis Hurst, Emory University School of Medicine, Atlanta, Ga., lectures on "Cardiology — Diagnostic Points, Part I;" Dr. Joseph H. Patterson, Emory University School of Medicine, Atlanta, Ga., on "Renal Diseases and Disorders of Children;" and Col. James B. Hartgering, Walter Reed Army Medical Center, Washington, D. C., on "The Worldwide Fall-Out of Nuclear Fission Products." At the afternoon session the lecturers and their subjects are: Dr. Edward L. Compere, Northwestern Uni-

versity Medical School, Chicago, Ill., "Whiplash Injuries of the Neck;" Dr. Robert F. Dickey, Foss Clinic, Danville, Pa., "Common Dermatoses Seen in Office Practice;" and Dr. Patterson, "Chest Diseases in Childhood." A question and answer period closes this session.

Only morning sessions are scheduled for Friday and Saturday. On Friday morning Dr. Compere will lecture on "Upper Extremity Fractures," Dr. Dickey on "Dermal Manifestations of Diabetes Mellitus," and Dr. Hurst on "Cardiology — Diagnostic Points, Part II." A question and answer period will follow. On Saturday morning Dr. George Crile Jr., Cleveland Clinic, Cleveland, Ohio, and Col. Hartgering will be the featured speakers. Dr. Crile's two subjects are "Changing Concepts in the Nature of Cancer" and "Cancer of the Thyroid and Breast." Col. Hartgering's lecture is entitled "The Response of Man to Ionizing Radiation."

An Impressive Record

After almost a half century of service to the American Medical Association, Thomas R. Gardiner has given up his full time position as business manager of that organization. Back in 1909, at the age of 18, he sought a job at the A. M. A. office and began his career there by making up ad dummies for A. M. A. publications, checking advertising records and copy, and editing display and classified ads. Since then he has handled every phase of work in the advertising department. Since 1913, when he took over technical exhibits, the total annual revenue from that source has increased 34 times. He was appointed business manager in 1945, and since that time the yearly advertising revenue has increased about 400 per cent.

Fortunately, the benefit of his invaluable experience will continue to be available for he will stay on as a consultant on advertising and conventions. His many friends may continue to look forward to seeing him at the annual and clinical meetings and may still seek his wise guidance at A. M. A. headquarters in Chicago, where he will maintain an office. During his long tenure of office he has come to be known as "a fast-moving, untiring worker, who has a knack for making friends among doctors, advertisers, exhibitors, and fellow employees." The staff of The Journal of the Florida Medical Association salutes Tom Gardiner as friend and counselor, congratulates him on his impressive record of service and wishes him well in his new advisory post.

His successor as Advertising Manager and Director of the Technical Exhibition is Robert J. Lyon, who has assisted him for the last 11 years. He may be counted on to follow in the footsteps of his illustrious predecessor and make a distinguished record in his new post.

Another County Medical Society Employs Lay Executive Secretary



Miss Sigman

The announcement of the Broward County Medical Association that it has employed an Executive Secretary brings to five the number of component county societies of the Florida Medical Association now having a lay executive secretary. This society is to be congratulated on taking this step.

Chosen for this important post is Miss Sally Jane Sigman, who starts her professional career in this field at the age of 22. She is a graduate of East High School in Cleveland, Ohio, and has been employed as a medical secretary for four years. She is a member of the National Secretaries Association and of the National Registry of Medical Secretaries.

Executive secretaries of county medical societies have been invited to meet with Dr. Jere W. Annis, President-Elect of the Florida Medical Association, for breakfast Tuesday morning, May 13, at 8:00 in the Caribbean Room, Americana Hotel. This will be the second Conference of County Medical Society Presidents and Secretaries held in connection with the Association's Annual Convention.

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*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 Cases, Am. J. M. Sc. *232*:156 (Aug.) 1956.

SEARLE

OTHERS ARE SAYING

The Problem and The Forand Bill (Care of The Aged)

It has always been a tenet with me that, whatever the job, private enterprise can do it better than any other method. Today, there are many idea encroachments on that basic principle. Today, we hear doctrines and plans, by which, supposedly, all present problems are easily solved. Today we, also, have a problem: *How shall we care for the aged?* The Forand Bill merges all of these, in flood fashion, on the stage for a closer look, a careful study.

Recently, while discussing some of the problems of indigent care with some of our professional lay people, I was amazed at some of the prevailing attitudes. In mentioning that we need at least 2 more million dollars a year to do a good job at the County Hospital (Duval Medical Center), I was told that our approach to indigent care was archaic, behind the times, inefficient, and costly. . . "Why, if you pass the Forand Bill," I was told, "we could take the current expenditure for the medical center, buy insurance policies for the remaining indigents and let private practitioners care for the indigents under insurance' . . . "Protective insurance," an insurance friend continued, "is the way medicine in the future is to be financed, and the sooner everyone realizes this the better off we will be". . . Then a lawyer friend mentioned the all-too-obvious fact that Florida is a state that caters to the retirement groups of people. He continued by reminding me that it is no secret that insurance companies shy away from writing coverage for the aged; that the actual cost of coverage for this group (those over 65) is considerably higher than for the young and middle-age groups. "Why should Florida assume the financial obligation for the indigent care of the aged when in actuality this is a national obligation? It used to be, prior to the age of rapid transit and flexibility in travel, the aged were cared for in the home towns in which they grew and gave their youthful talent; now we in Florida inherit many of this group, a group whose non-inflated retirement payments are adequate for living but inadequate for modern medical expenses — many fill our already overcrowded indigent facilities. Why not accept the Forand Bill and let the rest of the country help us with this problem?"

MOUNT SINAI HOSPITAL OF GREATER MIAMI

ANNOUNCES

8TH ANNUAL POSTGRADUATE SEMINAR

"Recent Advances in Diagnosis and Therapy"

May 22-25, 1958 — Deauville Hotel — Miami Beach, Florida

PROGRAM

Herrman L. Blumgart, M.D., Professor of Medicine, Harvard Medical School
1. "Clinicopathological Correlation of the Coronary Circulation"
2. "Relationship of Thyroid to Heart Disease"

Frederick Fitzherbert Boyce, M.D., Professor of Clinical Surgery, Tulane University School of Medicine
1. "Improved Outlook of Carcinoma of Stomach"
2. "New Concepts in Surgery of Biliary Tract and Pancreas"

Dwight Harken, M.D., Associate Clinical Professor of surgery, Harvard Medical School
1. "New Horizons in Heart Surgery"
2. "Surgery of Acquired Valvular Disease"

Robert M. Kark, M.D., Professor of Medicine, University of Illinois College of Medicine
1. "Clinical Value of Renal Biopsy"
2. "Disease Associated with Alcoholism"
3. "Medicine and Nutrition in Arab Kingdom of Libya" (Movie)

Hans Popper, M.D., Director of Pathology, The Mount Sinai Hospital, New York; Professor of Pathology, Columbia University
1. "Clinicopathological Correlation in Hepatitis"
2. "Pathways of the Formation of Hepatic Cirrhosis"

Steven O. Schwartz, M.D., Attending Hematologist, The Hektoen Institute for Medical Research of the Cook County Hospital, Chicago
1. "Present Concept of Pernicious Anemia and Pernicious Anemia-like Diseases"
2. "Value of Clinical Observation in the Diagnosis of Hematologic Diseases"

Leroy D. Vandam, M.D., Clinical Professor of Anesthesia, Harvard Medical School
1. "Present Status of Hypothermia in Anesthesia and Surgery"
2. "Problems in Anesthesia for Patients with Heart Disease"

SYMPOSIUM (1)
"Unusual Surgical Emergencies"
Frederick Fitzherbert Boyce, M.D., Moderator
Dwight Harken, M.D.
Leroy D. Vandam, M.D.
George R. Prout, M.D., Assistant Professor of Urology, University of Miami School of Medicine

SYMPOSIUM (2)
"Critique of Recent Approaches to Heart Disease"
Herrman L. Blumgart, M.D., Moderator
Robert M. Kark, M. D.
Dwight Harken, M.D.
Hans Popper, M.D.
Robert Boucek, M.D., Associate Professor of Medicine, University of Miami School of Medicine

REGISTRATION FEE: $20—Mail check to Medical Secretary, Mount Sinai Hospital. No charge for medical students, interns and residents.

Approved for Category I, American Academy of General Practice

Then another chimed in, and wanted to know why some insurance policies gave better protection than Blue Shield and Blue Cross with less premiums. I thought of Blue Cross' Phililoo Bird presentation and how some insurance companies walk off with the good, top-of-the-mountain risks leaving Blue Cross and Blue Shield with the poor, down-in-the-valley risks. Is this private enterprise, I thought. Is this private enterprise for the Blue plans to yell from the hill tops, singing the blues "you have the good risks, we are stuck with the poor," all to the tune of "I get the neck of the chicken." Isn't private enterprise free, fair competition, sung more to the tune of "anything you can do I can do better?"—let's participate.

One could spend hours arguing and debating the truths or non-truths of the aforementioned assertions and use up many reams with counter arguments. Really and truly, we would not be touching the real problem—the real problem is *care for the aged indigent.*

There is little doubt that private enterprise can handle this problem, better than the Forand Bill, better than government intervention, better than the present system. We must care for the aged's medical problems. Each of us is a humanitarian. Surely our humanism will force the complacency of free enterprise to solve this problem. The aged indigent will be cared for, better than he is cared for today, without government intervention.

Much can be done by private insurance companies, the Blue Plans included, offering to the old people benefit of voluntary health insurance. Yes, if necessary, cover everyone up to the age of a hundred and ten. Impossible!. . . . no!. . . . By prorating over the general population and at the same premium this can be accomplished. This, of course, may require some control, but not nearly the dictatorial control of government regimented medicine. Perhaps, a high commissioner of medical insurance, selected by insurance companies, could be set up to help prorate the risk more equitably, over the entire population. Each company would be required to accept the poorer risk in equal ratios to the good. A precedent has been set in the handling of workman's compensation risks. Whenever the "steeple jacks" and "ground hogs" have trouble getting coverage, the workman's compensation insurance commissioner prorates fairly and equally over the entire insurance industry these poor-risk groups. In the field of



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Unprecedented Low Dosage. Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. (1 to 2 tablets) maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides —a notable asset in prolonged therapy. [2]

New Control Over Sulfonamide-sensitive Organisms. KYNEX maintains the prolonged, high tissue concentrations of primary importance in treatment of urinary infections . . . a therapeutic asset toward preventing manifest pyelonephritis as a complication of persistent bacteriuria during pregnancy and puerperium. Maintenance of sterile urine in such patients was accomplished with 1 tablet of KYNEX daily. [3]

KYNEX*

Sulfamethoxypyridazine Lederle



Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours. Dosage in children, according to weight; i.e., a 40 lb. child should receive ¼ of the adult dosage. It is recommended that these dosages not be exceeded.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

References: 1. Grieble, H. C. and Jackson, G. G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958. 2. Editorial *New England J. Med.* 258:48-49,1958. 3. Jones, W. F., Jr. and Finland, M., Sulfamethoxypyridazine and Sulfachloropyridazine. *Ann. New York Acad. Sc.* 60:473-483, 1957.

*Reg. U. S. Pat. Off.

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sports, particularly baseball, many of their problems are solved by the coordinated efforts of such a commissioner.

Surely, with more standardization of private voluntary insurance we can solve our problem in a free enterprise economy. If we ignore the problem, hoping for it to solve itself, we'll find ourselves swamped in the current sea of socialism. Reutherian "logic" will engulf the modern practice of medicine. This last remaining island of free enterprise need not have a fading coastline, providing we act now and save ourselves the headache of continued procrastination.

Attention should be given the comprehensive or single major medical insurance as recently outlined by Dr. Elmer Hess in the February 1, 1958, issue of the J. A. M. A. This plan essentially includes a $25.00 deductible provision with the patient paying 15% of the excess of expense over $225.00 Proverbially, we remind ourselves to keep our eye upon the doughnut and not upon the hole.

Let us keep at all times our eye upon the problem! In this case it is the care of the aged. Solve the problem by private free enterprise means and the Forand Bill will have no basis in fact, for passage.

E. F. F. Jr.
Monthly Bulletin, Duval County Medical Society
March, 1958

Former Grady Hospital House Staff

An organization is being formed of all former members of the house staff of Grady Memorial Hospital, Atlanta. Two years ago, letters were sent to most former house officers, however, some were excluded because of incomplete addresses. If you did not receive a notice, or failed to reply, please contact Grady Hospital Clinical Society. Office: G-610, 80 Butler Street, S. E., Atlanta.

STATE NEWS ITEMS

A five day Seminar on Care of Premature Infants is being held May 19-23 at the Premature Demonstration Center, University of Miami School of Medicine, Jackson Memorial Hospital, Miami. It will consist of a series of demonstrations and lectures on various phases of premature care. Included are demonstrations of equipment and its use, discussions on feeding, skin care, infection and handicaps of prematurity and the newer developments regarding infection in nurseries. There will be specific suggestions regarding home care, parents instructions and nursery set-ups. Applications and additional information are available from the Bureau of Maternal and Child Health, Florida State Board of Health, P.O. Box 210, Jacksonville.

Dr. Jere W. Annis of Lakeland, President-elect of the Florida Medical Association, addressed a group in Dunedin recently on the subject "Modern Medical Education."

Drs. Donald W. Smith and James J. Griffitts of Miami, and Dr. George T. Harrell Jr. of Gainesville appeared on the program of the 104th Annual Session of the Medical Association of Georgia held April 27-30 at Macon. Drs. Smith and Griffitts presented "Blood Replacement and Transfusion Reactions" at the Orthopedics, Surgery, Anesthesiology, Pathology and Industrial Surgery Joint Section on April 28. Dr. Harrell discussed "Urinary Infections in Diabetes" at the Medicine, Chest, Diabetes and EENT Joint Section held Tuesday morning, April 29, and Dr. Griffitts presented a paper on "Erythroblastosis" at the Obstetrics and Gynecology, General Practice, and Pathology Joint Section on Tuesday afternoon.

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20-40%	55 %
More than 40%	32.5%

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'Cytellin' provides the most rational and practical therapy available. Without any dietary adjustments, it lowers elevated serum cholesterol concentrations in most patients.

In a number of studies, every patient who co-operated obtained good results from 'Cytellin' therapy. On the average, a 34 percent reduction of excess serum cholesterol (over 150 mg. percent) has been experienced.

In addition to lowering hypercholesteremia, "Cytellin" has been reported to effect reductions in C : P ratio, S_f10-100 and S_f12-400 lipoproteins, "atherogenic index," beta lipoproteins, and total lipids.

May we send more complete information and bibliography?

*'Cytellin' (Sitosterols, Lilly)

POLIO VACCINE Lilly

Dr. Sherman B. Forbes of Tampa has recently been appointed Florida State Chairman of the Professional Advisory Committee to the National Society for the Prevention of Blindness.

Dr. Nelson A. Murray of Jacksonville has been awarded a grant by the American Cancer Society for the continued investigation of a microscopic electronic scanner and computer.

The Second Interamerican Conference on Occupational Medicine and Toxicology will be held in Miami August 18-22. It is sponsored jointly by the medical schools of the Universities of Miami and Havana. With proceedings entirely in Spanish, the Conference will bring together specialists in occupational medicine and toxicology from a dozen Latin American countries, as well as physicians and industrial hygienists of many American industries with interests in Central and South America.

Dr. J. Harold Newman of Jacksonville was among the group of Florida physicians attending the meeting of the American Urological Association held the latter part of April in New Orleans.

Dr. Richard T. Farrior of Tampa will present a paper entitled "Cancer and Reconstructive Surgery of the Head and Neck" on the program of the Section on Laryngology, Otology and Rhinology of the American Medical Association during the annual meeting being held June 23-27 at San Francisco.

Dr. Harold D. Van Schaick of Miami Beach has accepted the chairmanship of the 1958 Florida Cancer Crusade.

The 54th annual meeting of the National Tuberculosis Association and the 53rd annual meeting of the American Trudeau Society is being held May 18-23 at Philadelphia. Among Florida physicians on the program are Dr. Eunice M. Lasche of Tampa, and Dr. Albert V. Hardy of Jacksonville.

(State News Items are continued on page 1264)



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Rapid and prolonged relief—with less intolerance. The analgesic and specific anti-inflammatory action of BUFFERIN helps reduce pain and joint edema—comfortably. BUFFERIN caused no gastric distress in 70 per cent of hospitalized arthritics with proved intolerance to aspirin. (Arthritics are at least 3 to 10 times as intolerant to straight aspirin as the general population.[1])

No sodium accumulation. Because BUFFERIN is sodium free, massive dosage for prolonged periods will not cause sodium accumulation or edema, even in cardiovascular cases.

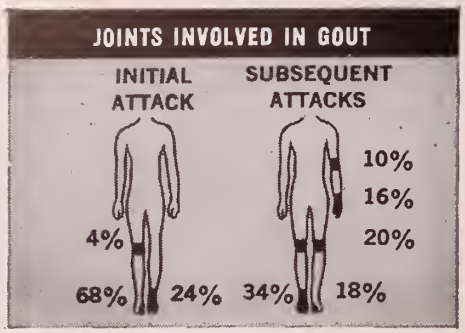
Each *sodium-free* BUFFERIN tablet contains acetylsalicylic acid, 5 grains, and the antacids magnesium carbonate and aluminum glycinate.

Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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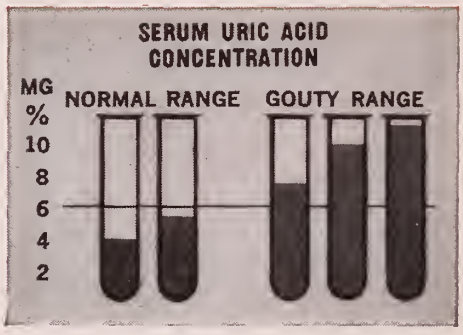

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1. Recurrent joint pain followed by long periods of complete remission. *(Percentages refer to incidence.)*



2. Enlargement of bursae such as in this case involving the olecranon bursa.



3. Elevated serum uric acid levels.



4. Colchicine test: full dose (0.5 mg.) every 1 to 2 hours until pain is relieved or nausea, vomiting or diarrhea occur. The test requires usually 8 to 16 doses. Pain relief is highly indicative of gout.

FROM THESE FINDINGS...SUSPECT GOUT:

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Once findings point to gout, long-term management can be started with BENEMID. This effective uricosuric agent has these unique benefits:

- Urinary excretion of uric acid is approximately doubled.
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- Uric acid deposits (tophi) in tissues are mobilized.
- Formation of new tophi can often be prevented.
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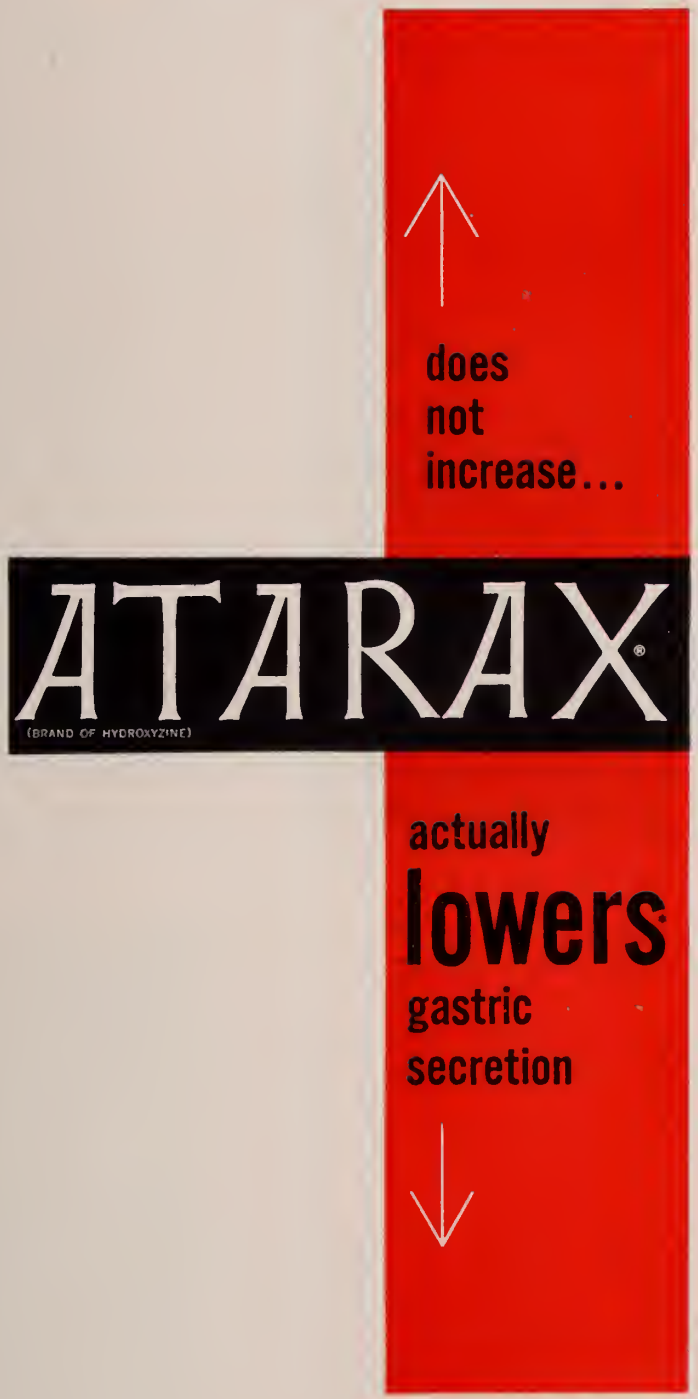
RECOMMENDED DOSAGE: 0.25 Gm. (½ tablet) twice daily for one week followed by 1 Gm. (2 tablets) daily in divided doses.

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*Tests in a series of 25 patients show that there is "a definite and distinct lowering [of both volume of secretions and of free hydrochloric acid] in the majority of patients. . . . No patients had shown any increase in gastric secretions following administration of the drug."[1]

Now you have 4 advantages when you calm ulcer patients with ATARAX:

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4. Five dosage forms give you maximum flexibility.

supplied: 10, 25 and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

references: 1. Strub, I. H.: Personal communication. 2. Ayd, F. J., Jr.: presented at Ohio Assembly of General Practice, 7th Annual Scientific Assembly, Columbus, September 18-19, 1957.

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Its pleasant, deodorizing fragrance also meets the esthetic demands of your patients.

Meta Cine is promoted exclusively to the medical profession, and recommends itself as your preparation of choice for patients who might otherwise indulge in unsupervised self-medication with potentially damaging nonphysiologic douches.

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Printed douching instructions for patients available upon request.



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G. B. Griffith, President

(Continued from page 1258)

The ninth annual publication of "Reviews of Medical Motion Pictures" is now available on request from the Film Library of the American Medical Association. This publication is prepared by the Council on Scientific Assembly, Motion Pictures and Medical Television and contains reprints of all film reviews published in The Journal of the American Medical Association during 1957.

Dr. Sidney Davidson of Lake Worth has been reappointed Governor for the State of Florida of the American Diabetes Association. The appointment is for a three year term expiring in June, 1960.

Dr. James B. Hodge Jr. of Tampa has been installed as president of the Hillsborough County Academy of General Practice. Serving with Dr. Hodge are Dr. Collin F. Baker Jr., vice president, and Dr. Robert H. Owrey, secretary-treasurer. Drs. Samuel H. Adams and Lester L. Zipser are new members of the board of directors. The physicians are from Tampa.

Dr. John E. Daughtrey of Lakeland, vice president of the Polk County Medical Association, was principal speaker at recent commencement exercises for Polk County's School of Practical Nursing held at Central School in Winter Haven.

Dr. George W. Karelas of Newberry has been honored by the Lions Club there "for his unselfish service to the community and his devotion to duty" and particularly for his work as chairman of the Committee on Rural Health of the American Academy of General Practice.

Dr. Roy W. Brown of Belle Glade was guest speaker at a recent meeting of the Civitan Club of that city. He explained the relationship between the local hospital, the physicians and the community.

Dr. Erasmus B. Hardee of Vero Beach represented the Florida State Board of Medical Examiners at the meeting of the Federation of State Boards of Medical Examiners held in Chicago.

Dr. Harry G. Brownlee of Zephyrhills discussed diseases of the coronary arteries and trends in

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ACTS FASTER...
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usually for 6 hours or more

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permits uninterrupted sleep through the night

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AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Available through all pharmacies.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Literature? Write

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*U.S. Pat. 2,628,185

the treatment of cardiac patients at a recent meeting of District 26, Florida Nurses Association, held at Dade City.

Dr. Harold B. Canning of Wewahitchka was given a surprise party by residents of that city in celebration of his birthday. The recent affair, held in the Community Building, was attended by approximately 200 persons and featured were tributes to Dr. Canning by community leaders. He was elected mayor of the city last year by the largest majority ever given any candidate.

A postgraduate refresher course to be held in Hawaii and on board the S. S. Matsonia August 5-21 is being offered by the University of Southern California School of Medicine. All sessions have been scheduled for week day mornings and several programs will be given simultaneously in order that each physician may have the opportunity to choose the subject most valuable to him. Information may be obtained from the Director of the Postgraduate Division, USC School of Medicine, 2025 Zonal Ave., Los Angeles 33, Calif.

The 1958 meeting of the American Goiter Association is being held June 17-19 in the St. Francis Hotel at San Francisco. The program for the meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland.

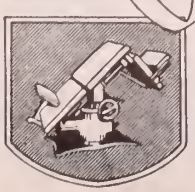
Dr. Robert Y. H. Thomas of Jacksonville discussed "The Importance of the Industrial Physician" at the first state-wide conference on "The Problem Drinker in Industry" held April 10-11 at the J. Hillis Miller Health Center, University of Florida, Gainesville. The Florida Medical Association cooperated in sponsoring the conference with the Florida State Board of Health, Florida Alcoholic Rehabilitation Program, Florida Federation of Labor, Florida Industrial Commission, Associated Industries of Florida and the General Extension Division of the University of Florida.

Dr. Ralph W. Jack of Miami, 1st Vice President of the Florida Medical Association, represented the Association at the annual convention of the Florida League of Nursing held April 10 at Miami.

Dr. Jere W. Annis of Lakeland, President-Elect of the Florida Medical Association, was principal speaker at a meeting of the Dunedin Rotary Club on April 22. His subject was medical education.

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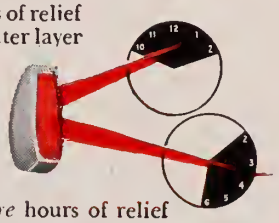
TRIAMINIC stops rhinorrhea, congestion and other distressing symptoms of summer allergies, including hay fever. Running nose, watery eyes and sneezing are best relieved by antihistamine *plus* decongestant action — systemically — with TRIAMINIC.

This new approach frequently succeeds where less complete therapy has failed. It is not enough merely to use histamine antagonists; ideally, therapy must be aimed also at the congestion of the nasal mucosa. Triaminic provides such effective combined therapy in a single timed-release tablet.

TRIAMINIC brings relief in minutes—lasts for hours. Running noses stop, congested noses open—and stay open for 6 to 8 hours.

Triaminic provides around-the-clock freedom from allergic congestion with just one tablet t.i.d. because of the special timed-release design.

first—3 to 4 hours of relief from the outer layer



then—3 to 4 *more* hours of relief from the inner core

Dosage: One tablet in the morning, mid-afternoon and at bedtime. In postnasal drip, one tablet at bedtime is usually sufficient.

Each timed-release TRIAMINIC Tablet contains:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

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TRIAMINIC Juvelets*, providing easy-to-swallow half-dosages for the 6- to 12-year-old child, with the timed-release construction for prolonged relief.

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TRIAMINIC Syrup, for those children and adults who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet.

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SOOTHING ACTION . . . Kaolin and pectin coat and soothe the inflamed mucosa, adsorb toxins and help reduce intestinal hypermotility.

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"... the degree of increase in exercise tolerance which sublingual erythrol tetranitrate permits, approximates that of nitroglycerin, amyl nitrite and octyl nitrite more closely than does any other of the approximately 100 preparations tested to date in this laboratory."

"Furthermore, the duration of this beneficial action is prolonged sufficiently to make this method of treatment of practical clinical value."

Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris, Circulation (Jan.) 1958.

*'Cardilate' brand Erythrol Tetranitrate SUBLINGUAL TABLETS, 15 mg. scored



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COMPONENT SOCIETY NOTES

Collier

Dr. Frank M. Bryan of Fort Myers was the principal speaker for the February meeting of the Collier County Medical Society held at the Naples Community Hospital. The title of his address was "The Diagnosis and Management of Early Coronary-Artery Disease."

Dade

Dr. Chester Cassel of Miami discussed "Cancer Detection in Dade County: Report of a Survey" at the April meeting of the Dade County Medical Association.

Duval

Dr. Emerson Day, Director of the Strang Cancer Detection Clinic, New York City, was guest speaker on the program of the April meeting of the Duval County Medical Society. Dr. Day discussed "The Application of Vaginal Cytology in a Community-Wide Project."

Franklin-Gulf

The Franklin-Gulf County Medical Society has paid 100 per cent of its state dues for 1958.

Hillsborough

A panel discussion of the subject "Proposed Blue Shield Changes" was the feature of the April meeting of the Hillsborough County Medical Association. Panel members included Drs. William C. Blake, C. Frank Chunn, Hershel G. Cole and David R. Murphrey Jr., all of Tampa. Mr. H. A. Schroder of Jacksonville, executive director of Blue Shield-Blue Cross, was present to comment and answer questions.

Lake

The March meeting of the Lake County Medical Society was held at the Mt. Plymouth Hotel at Mount Dora. Speaker for the evening was Dr. Jack H. Bowen of Jacksonville who discussed tumors of the skin.

Marion

The March meeting of the Marion County Medical Society was held at the Ocala Municipal Country Club at Ocala. Principal speaker was Mr. Richard Mills of Ocala, an attorney, who discussed the ramifications of malpractice.

Nassau

The Nassau County Medical Society has paid 100 per cent of its state dues for 1958.

Doctors, too,  *like "Premarin"*

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them – it replaces what the patient lacks – natural estrogen.

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why PETN? *For cardiac effect:* PETN is ". . . the most effective drug currently available for prolonged prophylactic treatment of angina pectoris."[1] Prevents about 80% of anginal attacks.

why ATARAX? *For ataractic effect:* One of the most effective—and probably the safest—of tranquilizers, ATARAX frees the angina patient of his constant tension and anxiety. Ideal for the on-the-job patient. And ATARAX has a unique advantage in cardiac therapy: it is anti-arrhythmic and non-hypotensive.

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

CARTRAX should be taken 30 to 60 minutes *before* meals, on a continuous dosage schedule. Use PETN preparations with caution in glaucoma.

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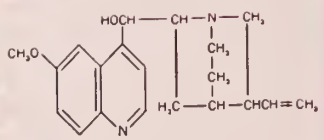
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"It has a high degree of clinical safety. . . It is considered to be the preferred antimalarial drug for treatment of disorders of connective tissue, because of the low incidence of gastrointestinal distress as compared to that with chloroquine phosphate."[1]

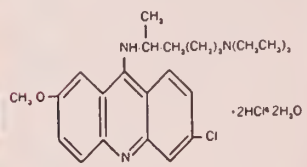
". . . Plaquenil is decidedly less toxic and better tolerated by the average patient, even in high dosage, than is chloroquine."[2]

". . . the least toxic of its class . . ."[3]

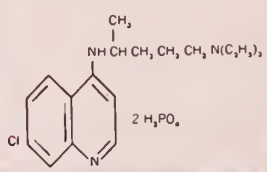
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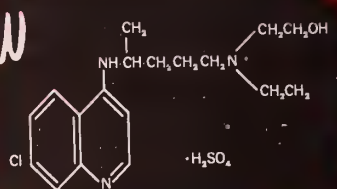
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Maintenance 200 to 400 mg. (1 or 2 tablets) daily.

SUPPLIED: Tablets of 200 mg., bottles of 100

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REFERENCES.
1. Ecberbel, A. L., Schnitker, B. L., and Harrison, J. C. [illegible], Apr., 1957.
2. Schoch, A. C., and Alexander, L. J.: The School [illegible] 5:75, Nov., 1956.
3. Cornbleet, Theodore: Arch. Dermat. 73:572, June, [illegible].

Atabrine (brand of quinacrine) Aralen (brand of [illegible]) and Plaquenil (brand of hydroxy[illegible])

Orange

The Orange County Medical Society has paid 100 per cent of its state dues for 1958.

Pasco-Hernando-Citrus

Dr. William C. Roberts of Panama City, President of the Florida Medical Association, was principal speaker on the program for the March meeting of the Pasco-Hernando-Citrus County Medical Society.

Pinellas

Dr. J. Rocher Chappell of Orlando, Chairman of the Committee on Civil Defense and Disaster of the Florida Medical Association, was principal speaker for the April meeting of the Pinellas County Medical Society. Dr. Chappell discussed "Medical Aspects of Civilian Defense."

Polk

Dr. Harold Carron of Tampa was guest speaker on the program of the February meeting of the Polk County Medical Association. The meeting was held at the Haven Hotel in Winter Haven. Dr. Carron discussed "The Place of Hypnosis in Modern Medicine." Dr. Albert G. King Jr. of Lakeland was in charge of the program.

Putnam

Dr. William C. Thomas Jr., Director of the Division of Postgraduate Education, College of Medicine, University of Florida, was guest speaker at the February meeting of the Putnam County Medical Society. Dr. Thomas discussed the program of postgraduate medical education of the University and showed photographs and plans of the development of the medical college.

Seminole

The Seminole County Medical Society has paid 100 per cent of its state dues for 1958.

Volusia

Dr. Luther W. Brady Jr., Hospital of the University of Pennsylvania, Philadelphia, discussed "Carcinoma of the Breast" at the March meeting of the Volusia County Medical Society.

County medical society presidents and secretaries have been invited to meet with Dr. Jere W. Annis, President-Elect of the Florida Medical Association, for breakfast Tuesday, May 13, at 8:00 in the Caribbean Room, Americana Hotel. This will be the second Conference of County Medical Society Presidents and Secretaries.



* J.A.M.A. 166:158,1958; Welsh, A.L. and Ede, M.
"...prompt remissions of...acute phases."
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* 1. Clyman, S. G.: Postgrad. Med. 21:309, 1957.
2. Bleiberg, J.: J. M. Soc. New Jersey 53:37, 1956.
3. Abrams, B. P., and Shaw, C.: Clin. Med. 3:839, 1956.
4. Welsh, A. L., and Ede, M.: Ohio State M. J. 50:837, 1954.
5. Bleiberg, J.: Am. Practitioner 8:1404, 1957.

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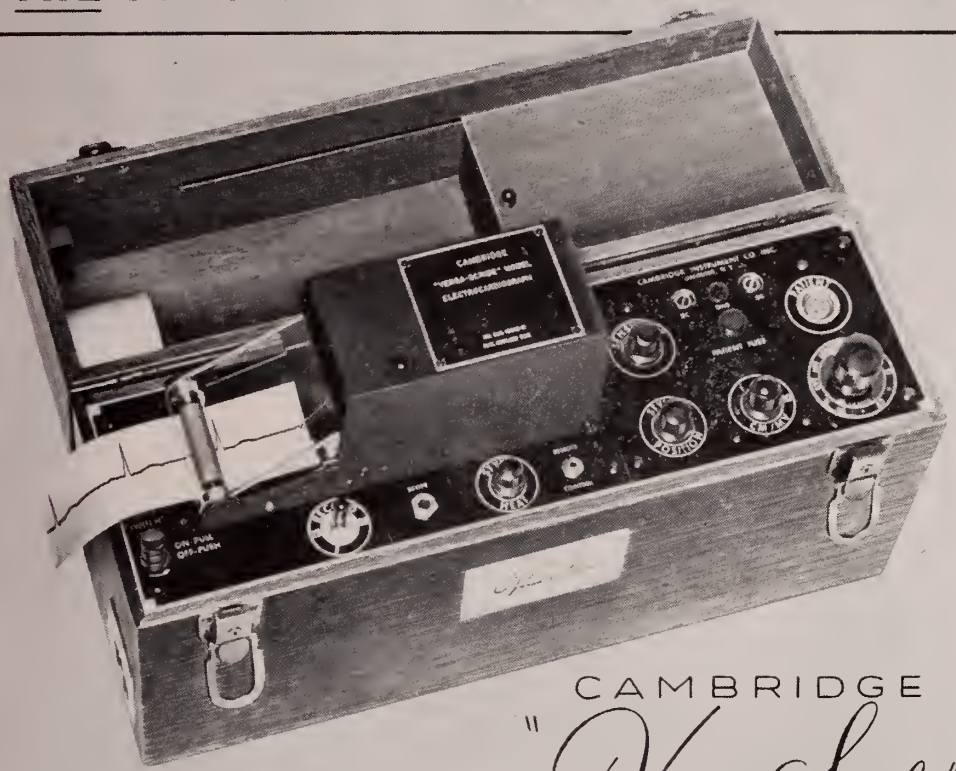
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base or the hydrochloride alone. In addition, the average levels derived from the tetracycline base or the chlortetracycline base were higher than those produced by the corresponding hydrochloride though lower than those resulting from the mixture containing the base and sodium metaphosphate. In the study with chlortetracycline[6] capsules containing a mixture of the hydrochloride and sodium metaphosphate were also included in the crossover, and the average levels produced by these capsules were the same as with the mixture of chlortetracycline base with sodium metaphosphate.

Although the enhancement of blood levels of tetracycline by phosphate, either complexed to the tetracycline or mixed with the base or the hydrochloride, thus seemed fairly well established, some doubts still remained because certain reliable observers (including many whose results have not been published) failed to confirm the findings with the materials and methods they used. Further confusion seemed to be added by a subsequent report of Welch et al.,[7] who, in repeating a crossover study with capsules of tetracycline phosphate complex and tetracycline hydrochloride with and without sodium metaphosphate, found [illegible]

antibacterial activity than was observed in their absence. Oil and sorbitol did not interfere with tetracycline absorption.

Dicalcium phosphate is widely used as a filler in various capsules, including those of the tetracyclines. The authors cite a large number of other studies that implicate the presence of calcium ions as the cause of the reduced absorption of tetracyclines and show that citric acid can partially neutralize this effect. The depressing effect of food on the serum levels of tetracycline is likewise explained by the goodly amount of minerals contained in commercial laboratory diets, and they postulate that the multivalent cations may be responsible for the poorer absorption of the drug. The authors could not explain the failure of citric acid to enhance serum concentrations when administered with tetracycline base in contrast to its marked effect when given as the hydrochloride. However, they hypothesized that the ability of citric acid to enhance serum levels of tetracycline is related to its ability to form complexes [illegible] unavailable for

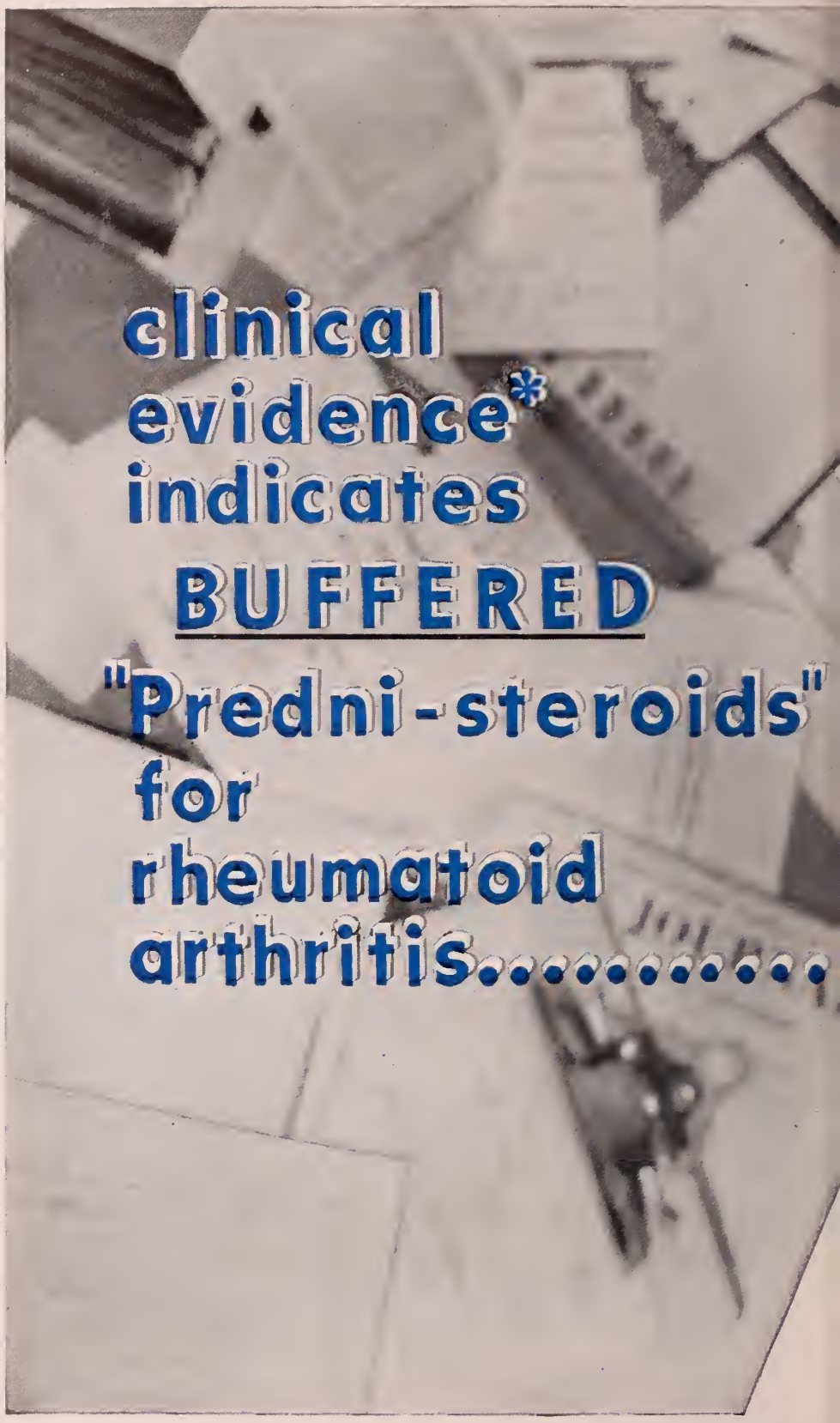
"...Tetracycline hydrochloride and citric acid, in an encapsulated mixture, produced higher serum concentrations and greater urinary excretions, and hence better absorption of tetracyclines, than any other preparation studied..."

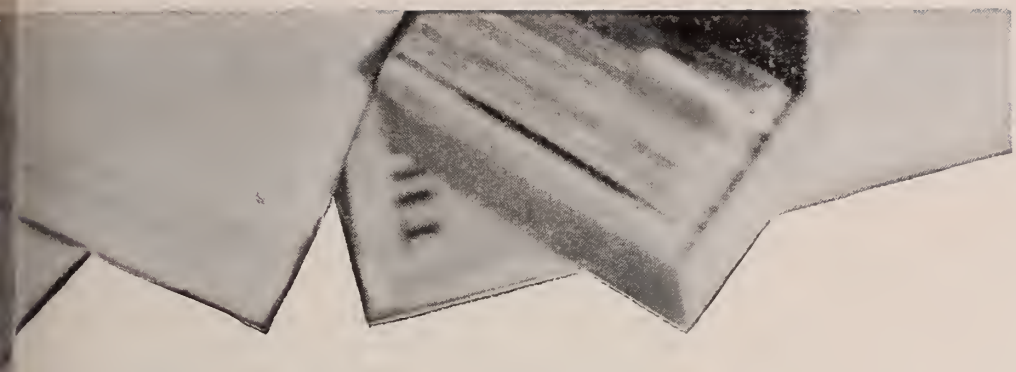
[illegible] to the last mentioned paper of [illegible] et al.[7] indicates that in their study the capsules of tetracycline hydrochloride, chlortetracycline hydrochloride and tetracycline phosphate complex all contained dicalcium phosphate as a filler, whereas the capsules containing citric acid and sodium hexametaphosphate did not contain any dicalcium phosphate. This could clearly explain the discrepancies noted in that study. Likewise, the inconsistencies in other studies may very well have been due to the [illegible] of calcium as fillers in some [illegible] others. [illegible] however,

Editorial.
The New England Journal of Medicine.
258:97-99, (January 9) 1958.

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view of the beneficial re- s observed when antacids nd diets were used concom- with prednisone and predni- we feel that these measures be employed prophylacti- offset any gastrointestinal ects."—Dordick, J. R. *et al.*: tate J. Med. 57:2049 (June 57.

*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine co-administration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:459 (June 11) 1955.

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Brenner, Robert L. Jr., Ft. Lauderdale
Bussey, Dan R., Pompano Beach
Clarke, William P., Jacksonville
Cole, John H., Orlando
Dailey, James O., Bunnell
De Padua, Virgilio B., Jacksonville
Dietrich, James F., Live Oak
Dussia, Evan E., Tallahassee
Edwards, Thomas S., Jacksonville
Ersay, Emil F., Pompano Beach
Failmezger, Theodore R., Clearwater
Favis, Edward A., Daytona Beach
Goodless, Maxwell D., Hollywood
Greenwell, George R., Brandon
Griffith, Daniel P., Winter Haven
Hall, James A., Mims
Hoffeld, George D., Groveland
Johnson, Benjamin A. Jr., Jacksonville
Kesler, Robert M., Mount Dora
Knorr, Keith H., Ocala
Knotts, Benjamin F. Jr., Cocoa Beach
Kurzweg, Frank T., Miami
Langley, Warren F., Pompano Beach
Lucas, Roy H., Winter Haven
McConnell, Ben H., Lakeland
McKell, Joseph P., Tampa
Miles, Clifford B., Pompano Beach
Moore, John C., Lakeland
Newbill, Cannon E. Jr., Jacksonville
Oyen, William, Lake City
Quick, James C., Lakeland
Radkins, Laurent V. Jr., Fort Myers
Roll, Edmund C., Orlando
Sager, Samuel O., Venice
Scott, Thomas C., Cocoa
Scotti, Thomas M., Coral Gables
Squires, John B., Ft. Lauderdale
Stanton, Robert L., So. Miami
Tumlin, Paul F., Leesburg
Weiner, Harry S., Miami Beach
Welch, William B., Miami
Welebir, Andrew J., Winter Park
Wilhelm, Richard J., Jacksonville
Woulfe, James C., Ft. Lauderdale



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Newborns are fed at 3 to 4 hour intervals throughout the 24-hour period—the 2 or 3 A.M. feeding is discontinued after the neonatal period. In the third or fourth month the 10 or 12 P.M. feeding is discontinued, once the infant fails to awaken for the bottle. Standard but individualized formulas which constitute the hospital infant feeding regimen are shown here.

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Age Months	Cow's Milk Fluid Oz.	Water Oz.	KARO Tbsp.	Each Feeding Oz.	Feedings in 24 Hrs.	Total Calories
Birth	10	10	2	3	6	320
1	12	13	2½	4	6	390
2	15	13	3	4½	6	480
3	17	9	3	5	5	520
4	20	11	3½	6	5	610
5	23	11	4	6½	5	700
6	26	10	4	7	5	760

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Age Months	Evap. Milk Fluid Oz.	Water Oz.	KARO Tbsp.	Each Feeding Oz.	Feedings in 24 Hrs.	Total Calories
Birth	6	12	2	3	6	380
1	8	16	3	4	6	532
2	9	14	3	4½	5	576
3	10	15	3½	5	5	650
4	12	18	4	6	5	768
5	12	21	4	6½	5	768
6	13	22	4	7	5	768

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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.

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WANTED: General Practitioner with Florida license to associate with 48 year old G. P. in S. E. Florida city. No investment. Reply full details, military service. Send photo. Write 69-267, P. O. Box 2411, Jacksonville, Fla.

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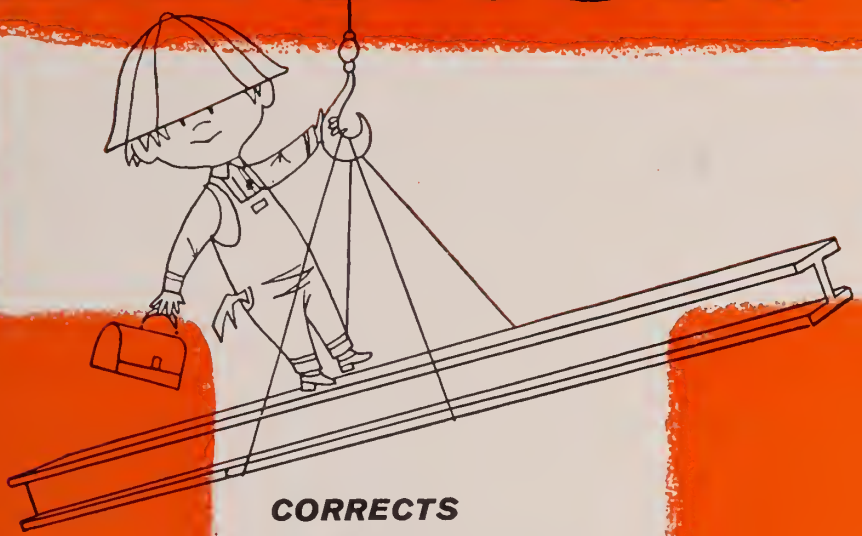
American Medical Golfing Association Announces Forty-Third Tournament

The American Medical Golfing Association i holding its forty-third annual tournament June 2 at the Olympic Lakeside Golf and Country Club San Francisco, in conjunction with the conventio of the American Medical Association.

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FORMULA: Each teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
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Thiamine Mononitrate (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Alcohol	0.75%

Average dosage is 1 teaspoonful daily.
Available in bottles of 4 fl. oz.

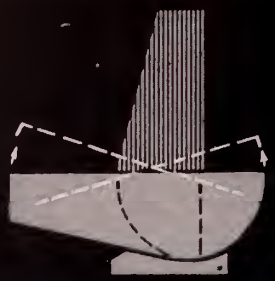
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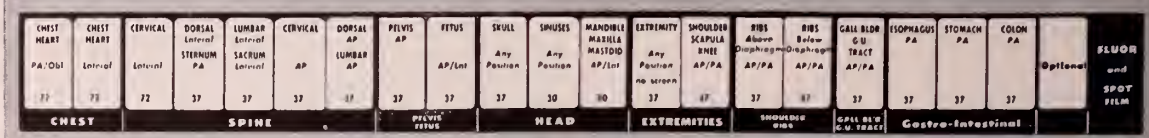


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3 Tetrex has an impressive documented record of clinical effectiveness

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OBITUARIES

Coleman Graves Buford

Dr. Coleman Graves Buford of West Palm Beach died on Dec. 23, 1957. He was 85 years of age.

Born in LaFayette County, Mo., on Jan. 25, 1872, Dr. Buford received his medical training in Illinois. In 1894, he was awarded the degree of Doctor of Medicine by the Northwestern University Medical School in Chicago. After serving two years as resident physician of Illinois Hospital Service in preparation for neurologic surgery, he became an instructor in surgery at his alma mater, continuing in that capacity for 10 years, and for nearly half of that period was special private assistant to Dr. Christian Fenger, Professor of Surgery. Between 1900 and 1913, he was junior surgeon at Mercy Hospital for seven years, surgeon to Crippled Children's Hospital for six years and surgeon to St. Joseph's Hospital for four years. From 1913 to 1920, he was surgeon to Henrotin Hospital and to Policlinic Hospital, where he was Professor of Surgery at the Policlinic Post Graduate School.

In 1909, Dr. Buford became Assistant Professor of Clinical Surgery at the University of Chicago, the School of Medicine, in affiliation with Rush Memorial College, and during that period was head of the surgical division of Children's Memorial Hospital. He served as an associate member of the Medical Staff of St. Luke's Hospital from 1917 to 1935. In 1935 illness caused him to retire from Chicago. Thereafter, he practiced general surgery in Elizabeth, Ill., and served on the Surgical Staff of Deaconess and St. Francis Hospitals in Freeport, Ill.

In 1953, Dr. Buford came to Florida to reside at West Palm Beach. He became a member of the Palm Beach County Medical Society and since 1955 had held membership in the Florida Medical Association. A past president of the North Side Branch of the Chicago Medical Society, he was a past vice-president of the Chicago Surgical Society and a past president of the Jo Daviss Cancer Society. He was one of the founders of the American College of Surgeons and served for many years as a member and for a time as chairman of its Chicago Membership Committee. He was also affiliated with the Chicago Institute of

(Continued on page 1297)

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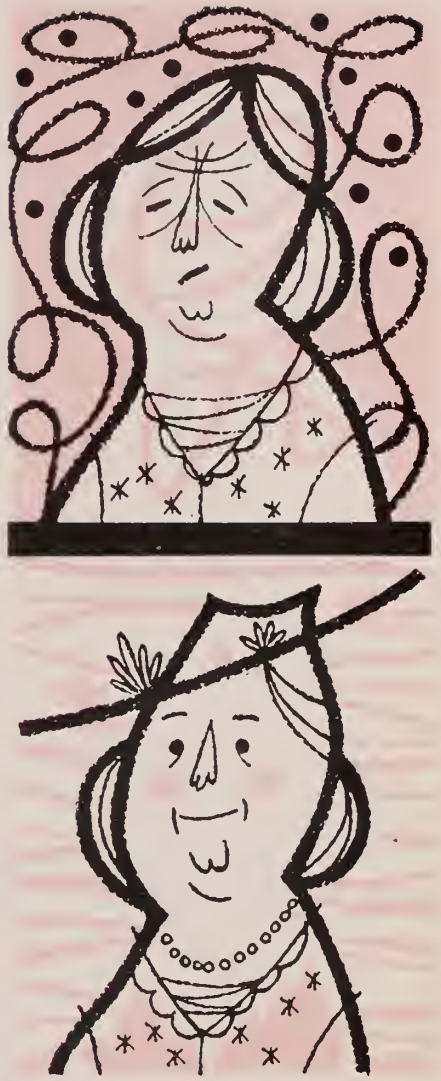
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Reserpine	0.25 mg.	(tranquilizer-sedative)

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1. Proctor, R. C.: Clin. Med. 6: 717 (June) 1957
2. Proctor, H. ., Bailey, W. H. and Morehouse, W. G.: J. Am. Geriatrics Soc. (April) 1958.



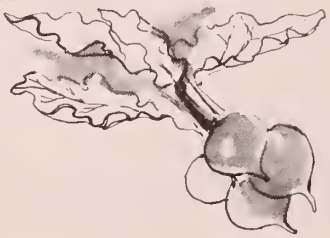
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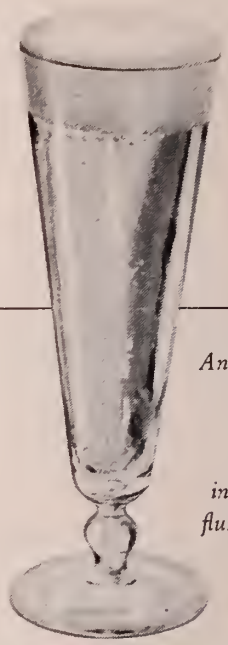
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For appetite appeal your patient can team apples with dates. Raisins or fresh cranberries make a tasty surprise in oatmeal muffins.

When your patient makes these bulk-producing foods appetizing, he's likely to include them in his regular diet.

*An 8-oz. glass of beer supplies about ⅛ the minimum requirement of Niacin as well as smaller amounts of other B Complex vitamins. (Average of American beers)

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The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin. ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

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Achrostatin V combines Achromycin† V ... the new rapid-acting oral form of Achromycin† Tetracycline... noted for its outstanding effectiveness against more than 50 different infections ... and Nystatin... the antifungal specific. Achrostatin V provides particularly effective therapy for those patients prone to monilial overgrowth during a protracted course of antibiotic treatment.

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Guild of Prescription Opticians of Florida

(Continued from page 1290)

Medicine, the Illinois State Medical Society and the American Medical Association.

Surviving are the widow, Mrs. Grace M. Buford; four sons, Coleman G. Buford Jr., Robert Lee Buford, Sam Walker Buford and John Buford; and two daughters, Mrs. Mary Cameron and Mrs. Margaret Speer.

John Terrell Moore

Dr. John Terrell Moore of Tampa died at a local rest home on Jan. 11, 1958. He was 74 years of age.

A native of Georgia, Dr. Moore was born near Canton on March 23, 1883. He attended rural schools and Waleska Junior College; later, he was graduated from North Georgia Agricultural College at Dahlonega. He began his professional career as a teacher in Turner County, Georgia, and at the age of 26 was elected county school superintendent. After teaching five years he enrolled in Emory University School of Medicine. He studied medicine during the day and at night took a course in pharmacy which he finished in two years. Completing his medical training with a high scholastic average, he was awarded the degree of Doctor of Medicine by Emory University on June 1, 1916. During his senior year he was vice president of his class.

Returning to Turner County, he practiced medicine and surgery there until 1925. He engaged in postgraduate studies in New York, Boston, New Orleans and Chicago. For one year, while in Chicago, he was assistant chief surgeon in the American Hospital. During World War I, he served as a first lieutenant in the medical corps.

In 1925 Dr. Moore located in Tampa and continued to practice there for 32 years. He was a member of the staff of Tampa General Hospital, St. Joseph's Hospital and Centro Asturiano Hospital. Locally, he was a member of the American Legion and the Palm Avenue Baptist Church, and was a past president of the Seminole Civic Center. He was a Mason and had been a Shriner since 1909.

Dr. Moore was a member of the Hillsborough County Medical Association, the Florida Medical Association and the American Medical Association. He also held membership in the International Surgeons Association.

Dr. Moore's wife, the former Mamie Susan Lacy, and also a son recently preceded him in death. Survivors include three daughters, Mrs. Curtis D. Maddox and Mrs. Hector J. Caron of Tampa, and Mrs. Ira Haden of Plant City; two sisters, Mrs. G. W. Southern and Mrs. J. P. Southern of Marietta, Ga.; two grandsons, John Robert Moore of Bartow, and William Terrell Moore of Miami; three granddaughters, Mrs. Charles Haigler, Susan Caron and Cheryl Caron, all of Tampa; and one great granddaughter, Ann Haigler of Tampa.

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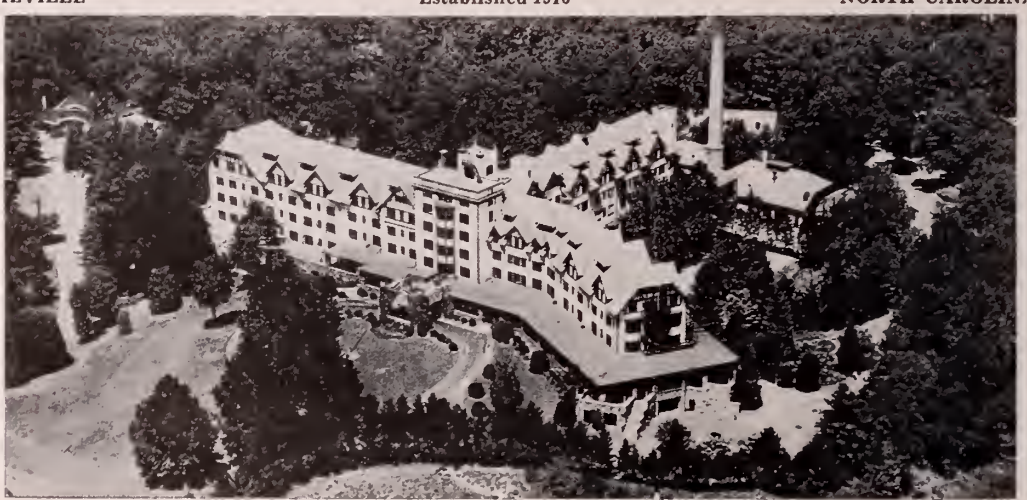
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l. & Otol., Soc. of	Carl S. McLemore, Orlando	Joseph W. Taylor Jr., Tampa	" " " "
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ns, Am. Coll., Fla. Chapter	Julius C. Davis, Quincy	C. Frank Chunn, Tampa	" " " "
cal Society	W. Dotson Wells, Ft. Lauderdale	Edwin W. Brown, W. Palm Bch.	Miami Beach, May 11, '58
—			
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an Medical Association	David B. Allman, Atl'tic City, N.J.	Geo. F. Lull, Chicago	San Francisco, June 23-27, '58
A. Clinical Session			Minneapolis, Dec. 2-5, '58
rn Medical Association	W. Kelly West, Oklahoma City	Mr. V. O. Foster, Birmingham	New Orleans, Nov. 3-6, '58
a Medical Association	John A. Martin, Montgomery	Douglas L. Cannon, Montgomery	
, Medical Assn. of	W. Bruce Schaefer, Toccoa	Chris J. McLoughlin, Atlanta	
Hospital Conference	Mr. Pat Groner, Pensacola	Charles W. Flynn, Jackson, Miss.	Miami Beach, May 14-16, '58
astern Allergy Assn.	Clarence Bernstein, Orlando	Kath. B. MacInnis, Columbia, S.C.	
astern, Am. Urological Assn.	Lawrence Thackston, Or'burg S.C.	S. L. Campbell, Orlando	
astern Surgical Congress	J. O. Morgan, Gadsden, Ala.	B. T. Beasley, Atlanta	
Coast Clinical Society	Lee Sharp, Pensacola	J. J. Baehr Jr., Pensacola	Pensacola, Oct. 23-24, '58



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** Baker*				
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Which plasma proteins may be hazardous in renal disease?



The globulins. They are more easily precipitated to form casts with blockage of renal tubules. The greater the damage to the glomeruli, the greater the proportion of urinary globulin to albumin and subsequent tubular impairment.

Source—Hoffman, W. S.: The Biochemistry of Clinical Medicine, Chicago, The Year Book Publishers, Inc., 1954, p. 233.

colorimetric "dip-and-read" test for proteinuria

just dip...

ALBUSTIX® Reagent Strips
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REFERENCES: (1) Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M.A.J.* 77:844 (Nov. 1) 1957. (2) Schneierson, S. S.: *J. Mt. Sinai Hosp.* 25:52 (Jan.-Feb.) 1958. (3) Hasenclever, H. F.: *J. Iowa M. Soc.* 47:136, 1957. (4) Rhoads, P. S.: *Postgrad. Med.* 21:563, 1957. (5) Caswell, H. T., and others: *Surg. Gynec. & Obst.* 106:1, 1958. (6) Josephson, J. E., & Butler, R. W.: *Canad. M.A.J.* 77:567 (Sept. 15) 1957. (7) Petersdorf, R. G.; Curtin, J. A., & Bennett, I. L., Jr.: *Arch. Int. Med.* 100:927, 1957. (8) Waisbren, B. A., & Strelitzer, C. L.: *Arch. Int. Med.* 101:397, 1958. (9) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 29:159, 1957. (10) Murphy, J. J., & Rattner, W. H.: *J.A.M.A.* 166:616 (Feb. 8) 1958. (11) Neter, E., & Hodes, H. L.: *Pediatrics* 20:362, 1957. (12) Woolington, S. S.; Adler, S. J., & Bower, A. G., in Welch, H., & Martí-Ibañez, F.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 365.

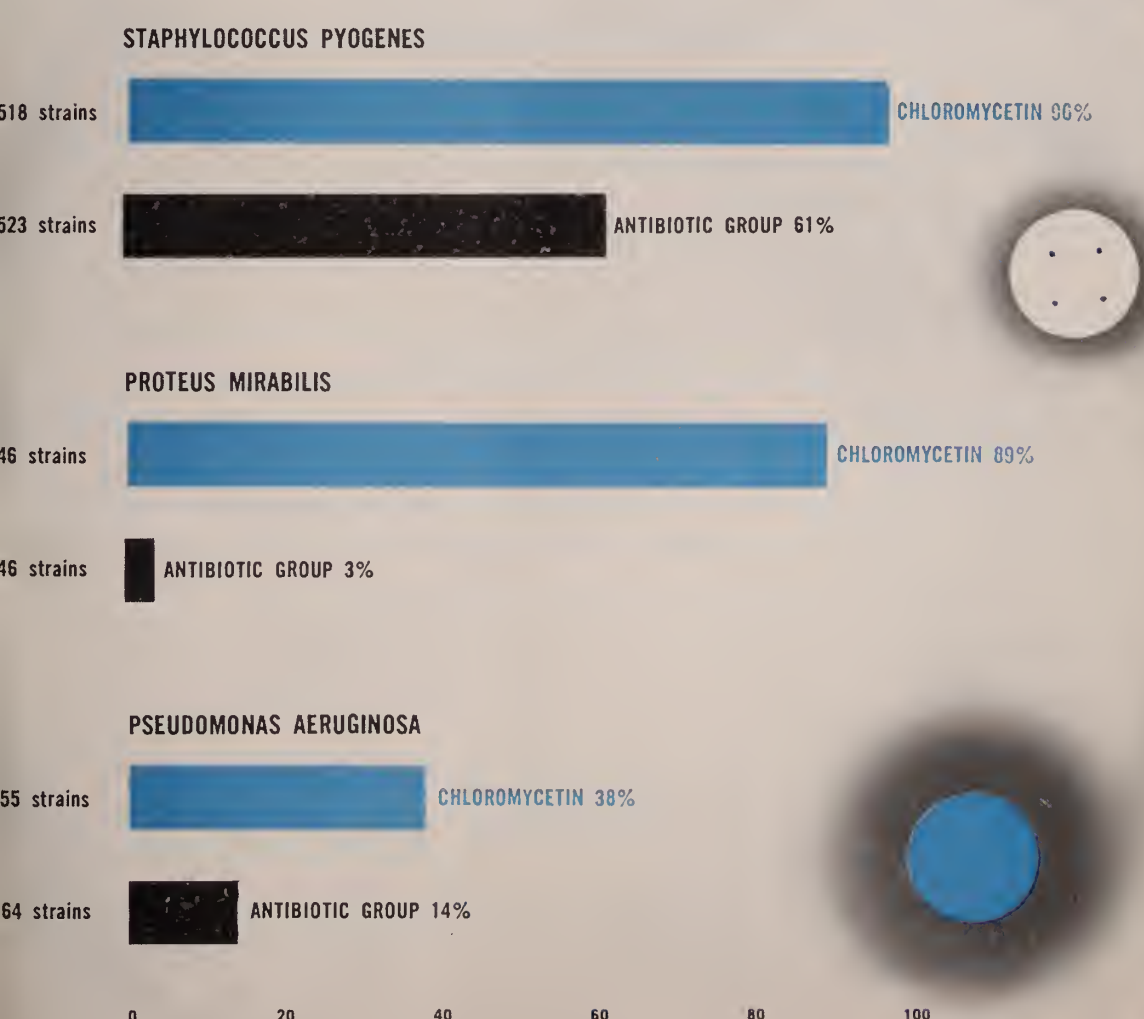
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VOLUME XLIV, No. 12 • *June, 1958*

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year: single numbers, 50 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924

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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. **32** 705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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1. Davis, C. H.: Trichomonas Vaginalis Infections: A Clinical and Experimental Study, J.A.M.A. *157*:126 (Jan. 8) 1955.

2. Pitt, M. B.: Leukorrhea, Causes and Management, J.M.A. Alabama *25*:182 (Feb.) 1956.

3. Lang, W. R.: Recent Advances in Vaginitis, Philadelphia Med. *51*:1494 (June 15) 1956.

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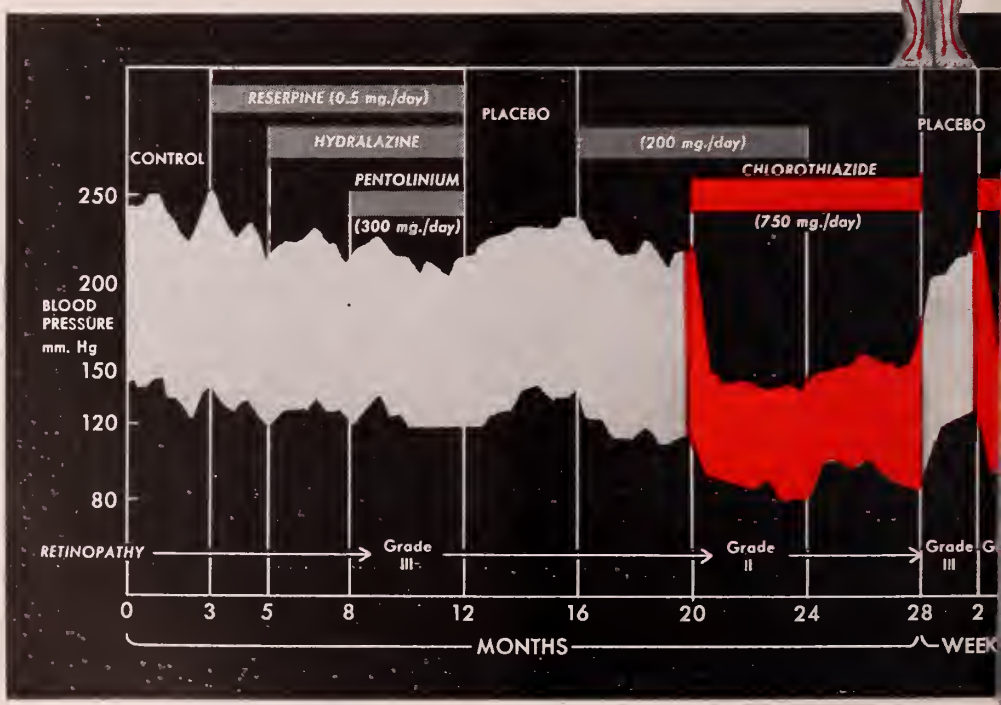
Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

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Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

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In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension,"
[1]Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, Septem

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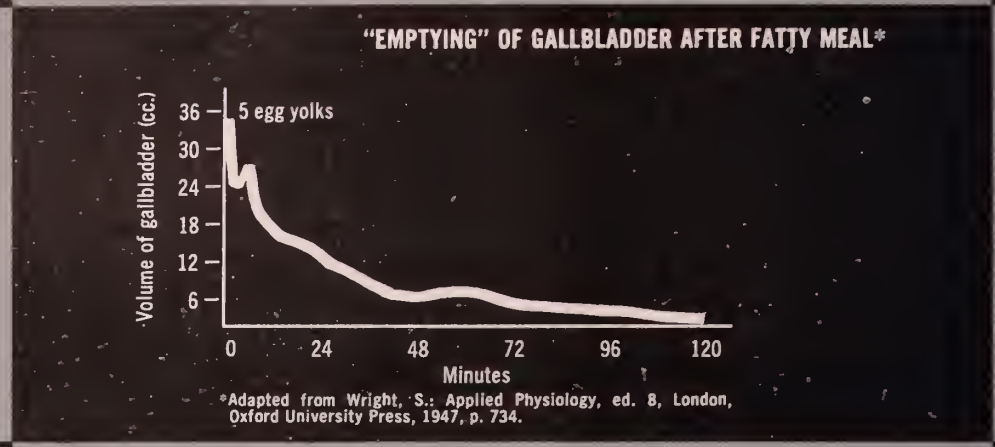
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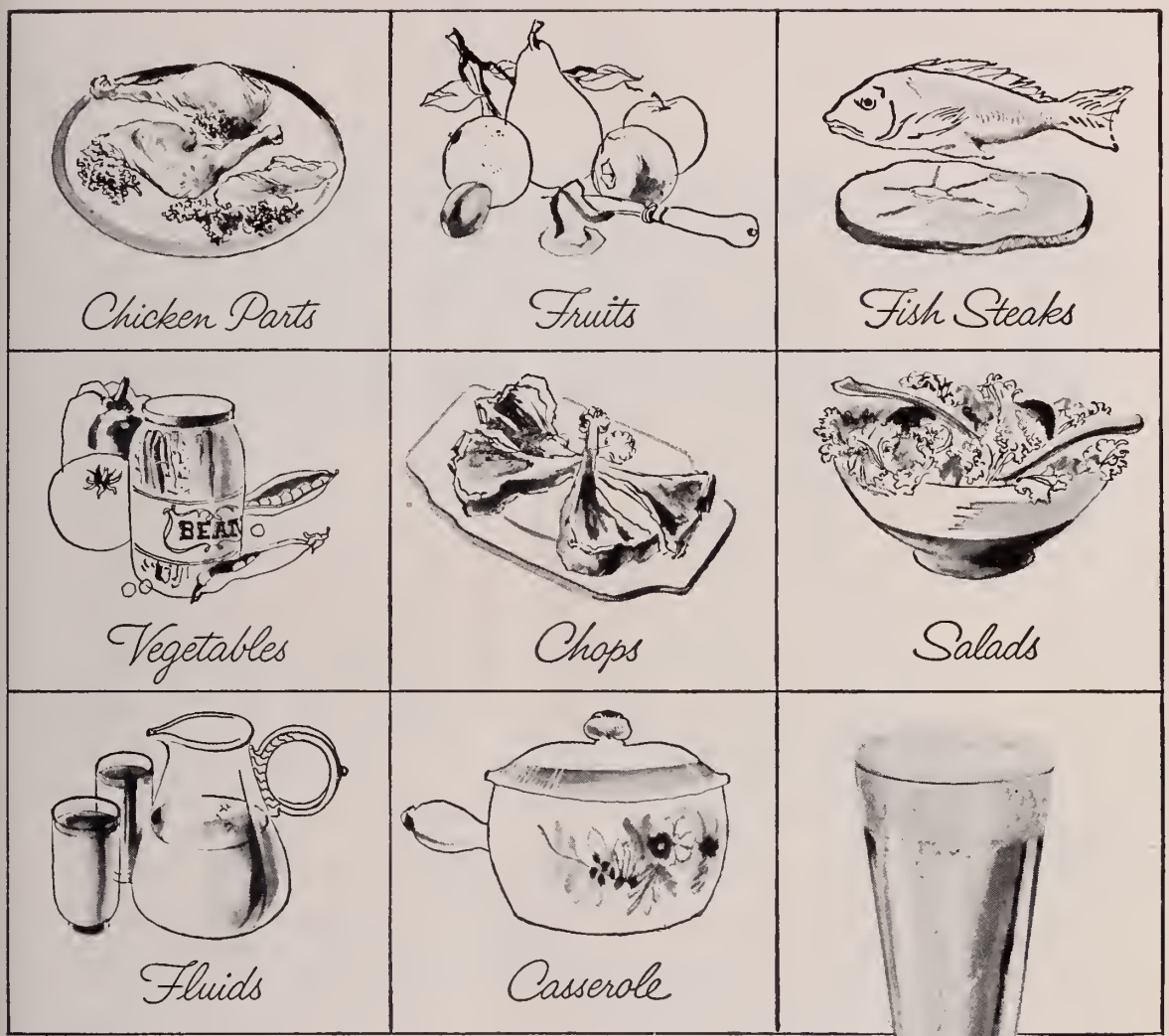
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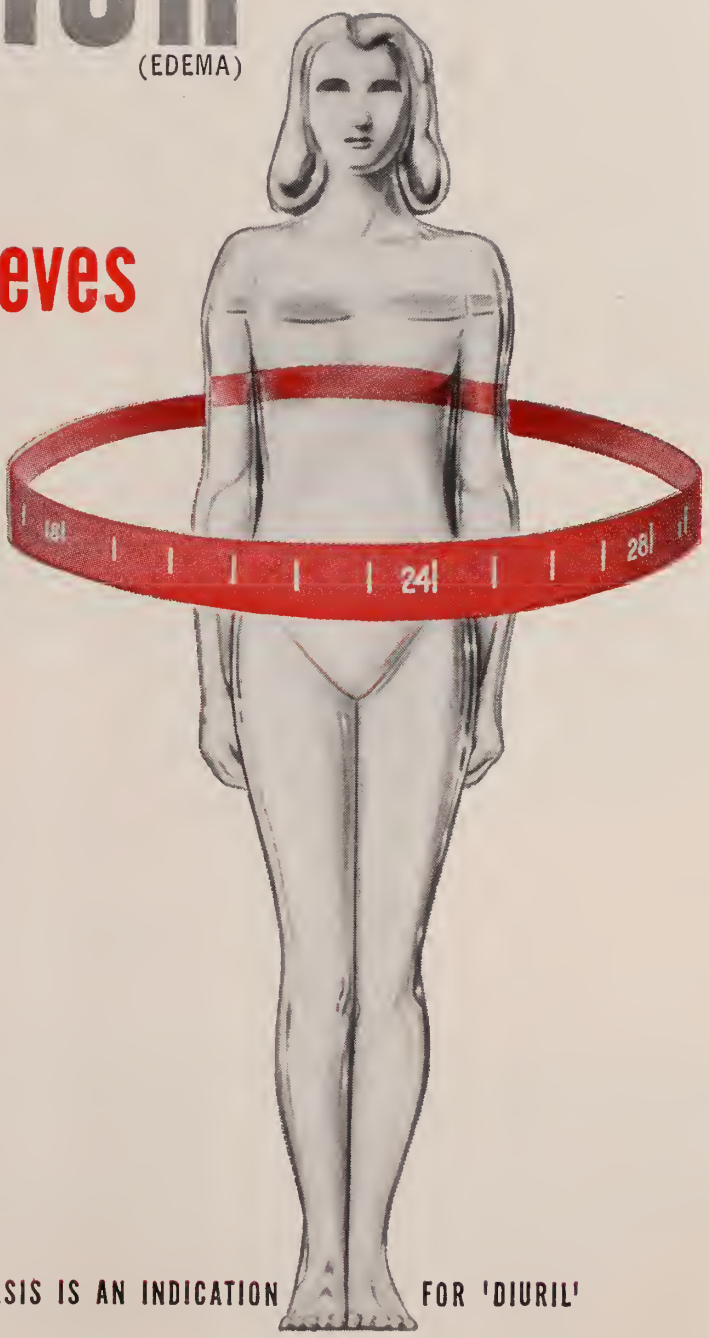
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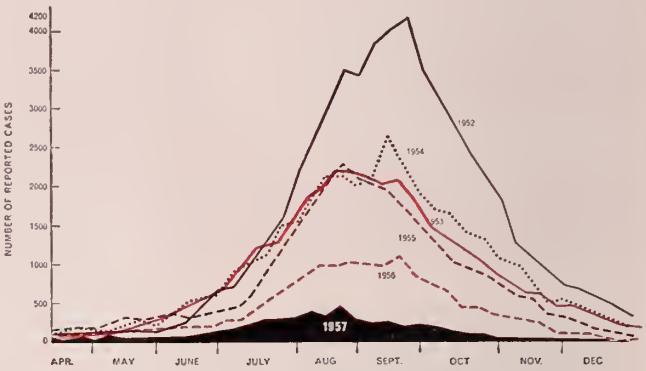
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1. *J. A. M. A.*, 165:21 *(November 23)*, 1957.
2. *Department of Health, Education, and Welfare: News Release, October 10, 1957.*

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The Journal of The Florida Medical Association
PUBLISHED MONTHLY

Volume XLIV | Jacksonville, Florida, June, 1958 | No. 12

Emotional Growth and Development Of the Child With a Key to His Personality

Richard E. Wolf, M.D.
CINCINNATI

No one lives in a vacuum. Human living is a relatedness, a belonging, and successful living depends on the culture in which the individual finds himself. Each culture makes its own demands upon the individual. The criteria for successful living on Bali are very different from the criteria for successful living in the United States of America. To be a success in 1956 implies meeting certain requirements of living which did not exist in 1900. In our particular culture emphasis is placed on being independent, self-sustaining and contributing at the earliest possible time. When we realize that the human infant is the most dependent, the most helpless of the young of any species, that it takes almost 15 years before he reaches any degree of even biologic maturity, then we see what a tremendous amount of psychologic growing he must do before he can achieve the goals we set for him—to be a happy, self-reliant and constructive person in our society.

Early Infancy

In discussing the significance of the period of early infancy in the development of the personality, we often find ourselves assigning attitudes, thoughts, and feelings to an infant which are actually beyond the development of his nervous system. We refer frequently to the "sense of insecurity" that a two week old baby feels when he is hungry. Obviously, this infant does not lie in his crib and contemplate the fact that he is hungry. He does learn that his mother can end his discomfort; if she does not do it, then he remains uncomfortable, and mother is associated with this discomfort. The absence of a capacity for contemplation does not mean that this infant is not having feelings, nor does it mean he cannot respond on a very primitive level to a relationship with another individual. Sometimes we try to oversimplify matters and differentiate between the physical and emotional life of the child. This differentiation cannot be made even for the period of infancy because both his physical and his emotional life depend upon the mothering activities of his mother. Mothering is actually a continuation of the prenatal state. A mother stimulates his larger muscles through carrying her baby, stimulates his skin through stroking, stimulates his ears, and hearing, through talking to the baby.

The nervous system of the newborn infant is poorly integrated. Movements are random and on a reflex level rather than purposeful, coordinated and controlled. Even his sucking reflex may be poor, and the mechanism for regulating such vital functions as respiration, temperature control, and circulation may be immature. The mothering activities of the mother actually stimulate this poorly integrated, immature organism to better function. When we observe a newborn infant, we readily notice the effect of cuddling and stroking upon stabilization of his earliest physiologic functions, particularly respiration and circulation. Every pediatrician has seen babies who fail to thrive because of the lack of this essential stimulation. There is an inherent tendency on the part of the newborn infant to reach out for gratification. Ribble has called this "stimulus hunger." In the first few weeks this is expressed by his seeking the breast, reaching out toward it when he is hungry. A hungry newborn infant placed near his mother's breast will root and grasp the breast with his lips and begin to suck. Although this response has for its purpose the relief of hunger, the impulse expressed as an effort to secure food represents a primitive expression of a drive to turn to someone else for relief of discomfort.

This is the beginning, and in the process of development this drive culminates in a pattern by which the individual turns to the external world for gratification of both psychologic and physio-

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Read before the Florida Pediatric Society, Fall Meeting, Clearwater, Nov. 1, 1956.

logic hungers. We can speak of this as the drive to be loved and we can say that a biologic and physiologic bond between the infant and his mother is thus converted into a psychologic bond. The physical benefits that result in a state of well-being in the child foster a feeling of gratification from the external world. Because of this interrelationship of physical well-being and psychologic gratification, many pediatricians try to help mothers find the suitable feeding program based on the child's apparent needs, rather than by a predetermined and uniform schedule. There has been too much ballyhoo, as if this were such a new method of infant feeding. Is it really so different from a very old approach? Is it not based on an attitude that the human being instinctively tends to expect and to respond to contacts with another human being, and thus to socialize? Socialization and the ability to live with others are fostered when the child's first experience with his world is one of gratification rather than of frustration.

Since the child is so completely dependent for even physiologic needs, the first step in his healthy development is a capacity to sense a love of his mother, to have trust in her, and to turn to her to meet his needs. A child, reared under a regime where frustration is fostered and he learns to cry and fight for gratification, grows to become timorous in the face of hazards existing in the external world. Another meets the problem with anger and a hostile attack upon an environment that has proved frustrating and hostile to him. The mother whose love he needed made herself a difficult person to love. He may need other people to make up for this lack, but the means to obtain these contacts are not available to him. His need to be dependent, if satisfactorily met, allays his anxiety—the anxiety that has its roots in his own physical inadequacy to deal with the unknown. Anxiety in the infant may be manifested by a state of physical tension. This, all pediatricians have seen in babies.

Early infantile dependence is described as oral dependence because mouth activity is so prominent a part of infants' activity. I have sketched the importance of the sucking mechanism in maintaining biologic requirements, in acquiring food to meet nutritional needs. Most infants have strong sucking impulses which manifest themselves when food is not required. You know how babies will suck even though they have had adequate food and in the first days of life can be observed sucking their fists immediately after receiving adequate amounts of milk. Studies have shown that some sucking in older infants is brought about by inadequate sucking time during feeding. Children who have had inadequate sucking time, due either to nipples which flow too easily or to an inadequate amount of milk, may be more likely to suck thumbs later. Sucking offers gratification to the small baby over and above the gratification entailed in obtaining an adequate amount of food.

Since the child's first relief from any discomfort comes from satisfying physical hunger through sucking, this experience may lead to self administration of comfort when tension begins to develop and cannot be relieved in other ways. Thus children faced with discomforts other than hunger turn to a tried and true method of gratification and suck their thumbs. Thumb-sucking is the child's attempt to comfort himself when faced with situations of which he is afraid and in which he feels insecure. Instead of turning to mother, he turns back to himself and seeks gratification from his own thumb as he had been gratified by sucking in an earlier period of his development. Attempts, therefore, to stop thumb sucking forcefully only deprive the child of his limited amount of security and take away from him the one resource of which he is sure. When the child has had enough gratifying experiences from the external world, his thumb will no longer be necessary, and it is a characteristic of the human being to turn outward for gratification rather than to remain isolated and self dependent.

Since the early nursing period is of such great significance in the establishment of basic security for the child, it is not surprising that the weaning period may be extremely disturbing if the child is not ready to relinquish this oral gratification. The situation is the same whether the weaning is from the breast or from the bottle. If weaning is premature or abrupt, the child may react poorly since a type of gratification has been removed before he has learned another form of gratification. The support upon which he has depended has disappeared, and the mother, instead of allaying anxiety, now represents a stimulus for anxiety. Anxiety aroused by such experiences may manifest itself in a variety of symptoms. The child may refuse all food, or, if he does eat, may be unable to tolerate the food; diarrhea, constipation, or vomiting developing. Even a baby can react to this experience with anger because of his in-

ability to be rid of this anxiety. Such a hostile reaction (for it is hostile) may also express itself in refusal to eat or in vomiting, diarrhea or constipation. Or, he may indicate his disturbance by increased restlessness, sleeplessness or sucking his thumb. Whatever the symptom may be, the cause of the difficulty lies in the disturbance created by too sudden or too early withdrawal of the source of his gratification and the mobilization of more anxiety and tension than the organism can handle.

Society Begins to Impinge

By the end of the first year, the infant has progressed in his development, so that he is not so completely dependent upon others for gratification of his needs and desires. Now, in being able to crawl about, he can explore his environment with hands as well as mouth. He begins to make certain sounds as he attempts to communicate his feelings and desires vocally. He has long since become aware of sounds, of colors, of things, and of the possibility of playing with objects other than those directly given to him. He is now able to attempt to feed himself; he is able to smear his food over his high chair, himself and his mother. Because he is able to move about, he can reach many new goals and can give expression to his impulsive desires. At first, he has no concept of forces other than his own wishes. He feels himself omnipotent. As he is able to direct his behavior more, however, he soon realizes that his wishes may at times conflict with the wishes of his parents. He thus reaches the point at which the demands of society represented by his parent begin to impinge upon his freedom and sense of omnipotence. Society's earliest demands of conformity to certain standards are expressed through the parent's attitude of approval or disapproval for certain forms of behavior.

During the early phase of this development, the child is faced with a dilemma. He wants to express an impulse, but if he does, this act may jeopardize the gratification of an equally pressing need, the need to remain secure in the love his parents give him. Thus, his aggressive drive comes into conflict with his need to be loved, and anger as well as love is felt for the same parent who is responsible for this dilemma. The child gradually learns to conform in this early training period because he fears withdrawal of the parent's love and the emotional pain this withdrawal causes.

After weaning, the first impingement of society upon the child's primitive, instinctual impulses is toilet training. Toilet training is something that the mother wants from the child, not an activity that the young child desires for himself. Training instituted in the early months illustrates clearly the great premium placed in our culture on cleanliness and conformity. Actually, we know from neurophysiologic studies that the child is not capable of conscious control of bladder and rectum until sometime after he attains the upright position and walks; yet we know mothers who insist that their children were trained during the first year. How often we say to the mother that she is more trained to "catch" the child than anything else.

At about the time that conscious voluntary control of sphincters becomes possible, a psychologic change in the child occurs. Whereas, before, his mouth was the center of his universe, his interest is now partially displaced to the other end of his gastrointestinal tract. As a result, he becomes as interested in his excretory functions as his mother is in controlling them. Under optimum conditions, the child's interest in this function will facilitate toilet training since he will tend to imitate the activity of other members of the household, if allowed to come to these activities on his own as he does with other activities and uses of "gadgets." Under less desirable conditions, his interest and his mother's interest come into conflict and complicate the training program. This consciousness of his excretory capacity presents him with a conflict. Since the child has none of the feelings of revulsion for his bowel movements that have developed in his mother, her attitude has led him to believe that she too prizes his "possession," so that her demand that he give her this prized possession seems to him to be an aggressive act on her part. Since his attained control is evidence to the child of his own increased power and his ability to give or to hold back, he can express his aggression in this way, too. If his mother has been overdemanding and punitive in her toilet training, he can express his hostility towards her by dooming her attempts to failure. Toilet training thus becomes a battle between the mother and the child, and fathers can be drawn into it, too, as you know. The child, however, has the final control of the situation. If his hostility toward his parent is so great that, at least for the time being, he cannot value her love, nothing can bring him to toilet training for, after all, final success is entirely in his control.

Clinically, the confusions of this period are manifested in various ways. Severe constipation

may develop. Via his lower bowel the child is saying "I won't give it to you, I won't, I won't." Similarly, a child may refuse to comply to mother's schedule and refuse to urinate or have his bowel movement when he is on the toilet, only to soil himself immediately afterwards. We all know children who hide their bowel movements or smear them. This behavior is desperate behavior and may have its origin in the requirements of an overly zealous or punitive toilet training itself, or the parent may be overdemanding in too many other areas at the same time, thus arousing too much of his anger. It may also be that the mother has been a frustrating person in her entire relationship with her child, and as a result, he feels more hostile than loving toward her. It looks as if nature has given the child a way to frustrate the parent by refusing to comply in something that obviously is important to the parent.

Just as it was important for feeding experiences to be satisfactory and uncontaminated by other strong emotions, so is it important that toileting experiences take place without the emotions being involved and expressed through toilet behavior. A child who is helped to come to his toilet training with a warm permissive attitude and acceptance and approval when he "conforms," but who does not feel rejected and punished when he fails to conform, will give up his own primitive desires where his excretory functions are concerned for the demands and the standards of the parent he so loves and wants to please. Parents can be reassured that with such an attitude towards toileting (and in a household where a toilet is present) that a child will achieve this degree of civilization at least by the time he is three. The rewards of growing up are greater than the deprivations entailed.

Mastering Elementary Social Demands

As the child gradually learns to synchronize his desire to carry out his impulses with his wish to maintain the security of his relationship with the parent, there develops a greater capacity to divert his feelings away from himself, and he begins the struggle to master the elementary social demands. By now he has the capacity to give love as well as to receive it. He shows love for each parent without differentiation other than that encouraged by differences in their attitudes towards him. He loves the persons who have been the source of his security and his pleasure. This situation does not remain this way long, however, for the child normally turns with greater intensity to the parent of the opposite sex. Because of his preference for the parent of the opposite sex, the parent of the same sex becomes a rival for the other parent's love. Because he also wishes to be loved by his rival and senses the power of the rival over him, the situation is sensed as one fraught with danger. The ramifications of the problems of this domestic triangle are different for the boy and the girl.

Both the boy and the girl have been primarily dependent upon mother for security and comfort. In his later development, the love object for the boy does not change, and he still feels the strongest emotional response to his mother. This response, however, is now more intense and also has value in itself rather than solely for the preservation of his security. Thus, father becomes a rival for mother's love and a dangerous rival. Since father is large and strong, even if not actually punitive, he can punish the boy by destroying that which is most important to him at this time—his masculinity. Since he has observed that there are people anatomically different from him, he may relate this difference to the danger that he believes he is in. He thinks, "There are individuals who have lost something I have, and the same thing may happen to me." Such an event could only be the result of an attack of a hostile person who has been provoked, and he attaches this danger to his father with whom he feels so competitive. It is in this three to five year period that the little boy frequently expresses fears of doctors, dentists, bad men and boogiemen. His dreams are of being pursued by large frightening animals and giants. There may be excessive concern over minor bodily injuries, and the Band Aid period is on. For this reason, elective surgical procedures such as tonsillectomy and particularly circumcision are psychologically contraindicated during this period.

His fear of retaliation by his father for his hostile feelings is only one aspect of the conflict that creates anxiety and confusion for the boy. If relationship with his father has been satisfactory up until now, positive elements remain, and he wishes to be loved by his father and to be like him. Since mother loves father, the boy strives to be like father to share mother's love—sort of "if you can't lick 'em, join 'em." In order, however, to retain the love of the father and avoid the danger of retaliation, the little boy strives to be like his father, but renounces his mother as a love

object. This identification with the father gives him new security, and father is gratified to see his son become a real boy, more like him. Mother, too, responds positively to the masculinity of her son, and the child has gained his goal. Through this solution to his problem by taking into himself the ideal of his father, his own conscience comes into being. Now, he has a mechanism for control of his primitive impulses within himself and no longer needs the control from without as was necessary up until this time. The solution of this emotional problem frees energy that can now go into establishing relationships outside of the family unit, with the world beyond his family. There develops a greater capacity to socialize. He now takes steps towards making friends among his peers, and this contact in turn offers an outlet for his competitive feeling. His competitive activities are in the fantasy world; he plays cops and robbers or cowboys and Indians or "good guys against the bad guys." In becoming socialized, he participates in a team situation, obeys the laws of sportsmanship and fair play, shows loyality to friends and hostility to foes, all characteristics of the normal boy as he progresses through the school age, from five to 12 years.

For the girl the problem in the three to five year period is somewhat more difficult. Even though the boy experienced a change in his relationship, his primary love object remained the same—a female—his mother. In contrast, for her emotional maturation the girl turns to father and thus mother becomes a rival. Mother is, however, and has been, the object of her dependence and the source of her security. She struggles between her wish to have father as a love object and her fear of losing the security of mother's love. Ultimately, if the little girl is to attain healthy emotional maturation, she must find gratification and security in a feminine role. To do so, she identifies with her mother and, like the boy, incorporates the pattern of her rival parent and, in the process, establishes her conscience. She, too, then turns to outside contacts in order to lessen the intensity of her tie to the parent figures and diverts her energy into relationships outside of the family.

Having realized that pleasant adjustment to parents is not enough, that a bigger task is fitting into the outside world, the child is now primarily concerned with fitting into his group. He strives to pick up the language of the children on his street; he wants to wear the same kind of pants, to have the same haircut, to play the same games. The rules of the outside world do not have to be forced upon him; he enjoys conforming to them. Boys, particularly, begin to go in for team games such as cops and robbers and athletics in which sides and leaders are chosen and the play goes according to rules. This is the age when clubs and gangs begin. These children are proving to themselves that they can run a part of their own life on a cooperative basis without supervision of adults, that they can decide who is and who is not acceptable on the basis of their own codes of behavior. These codes become very strict indeed. The child who provokes fights unnecessarily or who uses unfair methods is frowned on, also the child who avoids a fight when fighting is the honorable course.

The individual child's conscience is becoming strong within, and the boy, particularly, at this age feels the need to control and make moral his aggressive instincts. He loves to dream of bold adventure, but it must be in the cause of virtue; it must be idealized. Conscientious parents sometimes fear that the artists and authors of comic books corrupt children's tastes. Actually, the themes of the comic book do not originate there, and children learn from reading them. These are the same themes as are found in the typical daydream of the middle age child. Whether the hero uses a ray gun from a jet-propelled plane or a bow and arrow, he always triumphs in the end and on the side of justice. We could cite examples of the child's impulse to fit into the group, to help organize the group and to set up standards of behavior to regulate his life and his possessions. In this way he is seeking to establish himself as a responsible citizen of the outside world. To accomplish all this, however, it is necessary for him to break down some of his dependence upon his parents, to assert his independence of them. In doing so, he protests against their standards in many little ways. He seems to throw over the table manners that were so well formed during the early period. He protests against his parent's choice of clothes for him. He resents having to wash his hands and brush his hair. He is apt to prefer his clothes to look sloppy not because they are more comfortable that way, but more because his parents want him to be neat.

Some of the difficulties of this age group are due actually to parents, school or the community failing to recognize the child's needs and capacity as well as his limitations. Too often the child

is expected to be an adult now that he is in school. He is suddenly expected to be able to control his behavior for six hours of the day in order to conform to the school situation. Think of the demands we put upon him: he must arrive at school on time, properly dressed, properly fed. He must sit quietly for three consecutive hours or be active, according to the plans of the teacher. Then he must go home for lunch, inhibit any desire to play, return to school on time and sit for another two hours in the unnatural situation of quiet and study. Six hours of his time are, therefore, occupied by regimented activities and, though as physicians we say that the growing child should have at least 10 hours of sleep at night which would theoretically allow eight hours of freedom for the child, parents often want to give him music or dancing lessons and to have him belong to scouts, clubs, and other groups. In addition, his parent rightfully feels he should take some responsibility in helping maintain the home he enjoys, and a few minor domestic chores come into the picture. Do we not really owe much respect to a child who comes even close to meeting the demands we as his parents and society place upon him during this growth period? Maybe he is doing better than the average adult about him.

Adolescence

The loosening up of the personality that takes place during late childhood is a prelude to the real growth that occurs in adolescence. Adolescence is a physical phenomenon with strong psychologic components. The emotional problems and the emotional growth have their origin in the physical changes that occur at puberty. There now develops in the youngster an intensification of his impulse to grow toward an adult orientation. The most obvious manifestations of the psychologic change fall into two categories. First, he becomes more self conscious. He is interested only in himself. No one else has problems, no one else exists except in relation to him. With this change comes a need to free himself from his parents and to establish himself as an adult. This may often be expressed by the denial of the standards imposed by parents and by an acceptance of a philosophy determined by the peer group. Secondly, there is a reawakening and intensification of sexual feelings and drive. Small wonder that the behavior of this age group is contradictory, difficult and confusing. Part of the confusion can be attributed to confusion in our culture. It is not a simple step to enter adulthood and the world as it is today. On the one hand the adolescent is accepted as a maturing adult. He may stay out later, he may attend dances, he is expected to handle some of his own money, he is encouraged to earn part of that money, and he may drive a car. He is expected to assume responsibility for his leisure time and to solve his problems himself or to seek help upon his own initiative.

On the other hand, parents and teachers are frightened by the apparent instability of the adolescent and tend to inhibit where freedom formerly was implied. Parents who during the late childhood years gradually gain confidence in his judgment now (and often without justification) become unsure of this unpredictable person's capacity to evaluate situations. This contradictory attitude is nicely illustrated in the common struggle of the adolescent and his parents concerning the hours of coming in at night. The adolescent is not only allowed, but is usually encouraged by his modern parent to date. The date may take any one of many forms that are acceptable provided the child returns at a stated hour. The magical hour, be it midnight, eleven, or one, must be respected—as if the set hour were the equivalent of a chastity belt. Because the adolescent is less predictable than the well adjusted preadolescent, the concern of the parents has some justification. The adolescent's control of his impulses is by no means complete.

To the adolescent, however, reality has become a confusing picture of opportunities dangled before him, but frequently snatched away before he enjoys them. During adolescence whatever equilibrium has been established in the past between primitive impulses, himself, and his conscience is now upset. The wish to be loved, now enhanced by the sexual urge, and the aggressive drive, and desire for independence, have increased in strength. He now wishes to grow up. This wish involves a need to tear away from the parent figure and instead to turn to himself and his peers for standards and support. He may alternate between excessive idealism and periods in which he tends to overthrow his own conscience. We observe the unstable, unpredictable behavior of the adolescent and the pronounced mood swings which in a more mature personality would have serious implications. It is because of this bizarre picture that many have said, half in jest and half seriously, that adolescence is a disease in itself.

His feelings of sexual inadequacy may seem to have a real basis in past experience. During the three to five year period he was confronted with the extent of his sexual inadequacy. Obviously, the little boy was not physically equal to his father and the little girl was equally ineffective in comparison with her mother. The child was faced with the fact that actually he could not compete with the parent of the same sex because the other parent looked upon him as a child and upon the marital partner as the sexual object. Adolescence does not suddenly result in a totally mature physical structure. The adolescent boy is not at all sure that he is an adequate man, nor does the girl necessarily feel that she is an adequate woman. This sense of inadequacy may lead to trial experience, or it may lead to a sense of incompetence and defeat. When the adolescent is concerned about his own potency, the need to depreciate the parent of the same sex may come into direct conflict with the wish to see the parent as a successful example of what he himself can become. He wishes, however, to be the idealized version of the parent of the same sex, and in this way he is reassured about his own potency. The sexual conflict of the adolescent is by no means the only conflict of this period. His second conflict centers around his emotional need to establish himself as an independent person when the social demands of the culture prolong his period of dependency.

The adolescent wishes not only to be an individual but an independent one and a grown-up one. Because of the inherent drive toward maturation, he has the urge to emancipate himself from the domination and protection of his parents. Accepting the advice of a parent is the acknowledgment of inadequacy which is intolerable. The only way to be an adult is to act like one.

Such a sense of emancipation is safe as long as the parent does not permit it in actuality. For to be truly adult means to have the ability to cope with all the anxieties of life without the protection and security extended to the child, and this is often too much for the adolescent. Although fighting for independence, the adolescent also wants to be dependent and taken care of. He is frightened by his own impulses to emancipate himself. If this fright becomes too paralyzing, he feels impelled to regress to the security of childhood and again becomes a dependent child.

Such confusion is inevitable between the parent and the adolescent. The adolescent wishes to be independent. To be so is frightening. As long as the parent gives support, it is safe to be independent. If, however, the parent permits the emancipation, the adolescent is frightened and regresses to dependency, feeling at the same time much neglected. As soon as the parent gratifies the adolescent's dependency needs, he feels stronger and with renewed vigor attempts to achieve independence.

The problems of adolescence are thus, in part, the inevitable struggles of growing from childhood to adulthood. The difficulties presented are to a certain degree inevitable during this transitional phase. It is obvious, however, that not only does the parent have to accept the growth of the child, but he needs to be flexible in maintaining a role that is supportive and accepting when the adolescent feels the need for a more immature parent-child relationship. The parent who is eager to force the child out of the protection of the child-parent relationship will not be of great assistance in the maturation process. The better-adjusted individual has learned to live with his own needs to be dependent as well as his striving to be independent.

Pediatricians, as they become more comfortable in dealing with adolescents themselves, can help parents understand them and thus contribute greatly to the total health of the next pediatric generation. Many pediatricians practice long enough to see the fruits of their labor in a second generation of their own practices and thus never feel their patients have outgrown them.

Children's Hospital.

Glaucoma for the General Practitioner

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ST. AUGUSTINE

In one out of 50 Americans over 40 years of age glaucoma will develop this year. These 800,000 men and women will slowly lose their sight from glaucoma because of ignorance and neglect.[1] One out of eight blind patients ophthalmologists see is a victim of glaucoma. The general practitioner is in the most strategic position to help in the control of blindness, particularly blindness from glaucoma, since he sees these patients earlier than does the opthalmologist.

Glaucoma literally squeezes the sight out of the eye. Basically, the process is one of decreased outflow versus constant inflow of aqueous, with subsequent rise in the intraocular tension.

The first tissues to suffer are the nerve fibers at the temporal edge of the optic disks. They are squeezed against the unyielding scleral ring, with a resulting nasal field defect (figs. 1 and 2). Next, the blind spot enlarges and prolongation of this defect meets the original nasal defect to cause further loss of visual fields (fig. 3).[2] If the process is unchecked, the field diminishes until even central fixation is lost (fig. 4).

Read before the St. John's County Medical Society, St. Augustine, Dec. 15, 1956.

Diagnosis

The acute type of glaucoma strikes suddenly, inflicting cloudy vision, and is usually associated with pain and redness of the eye. By its nature it is as a rule readily diagnosed, although the frequently associated nausea and vomiting of acute glaucoma may sometimes be confused with an abdominal pathologic condition.

Chronic glaucoma, the most frequent type, is insidious and works slowly and painlessly. An early complaint of patients may be only of momentary or transitory attacks of blurred vision which clear up in a matter of minutes. When investigated, these may be found to be due to early glaucoma.



Fig. 1.—The normal disk and scleral ring. From Duke Elder, Sir W. Stewart. Textbook of Ophthalmology, Vol. III, St. Louis, C. V. Mosby Company, 1947, p. 3350.



Fig. 2.—Shows early field defect from pressure of the temporal portion of nerve fibers against the unyielding scleral ring, left eye. From Berens, Conrad, editor,[2] pp. 18 and 70, Chap. XLI.

Another early suggestion of the possibility of glaucoma is evidenced by frequent change of glasses, none being satisfactory for long. This may be considered due to two factors: (1) the forward movement of the lens of the eye, and (2) changes in the refractive index of the transmitting media of the eye.[3]

Faulty dark adaptation may suggest this insidious disease. The cause of this defect, early in the disease, is not well understood, but is believed to be faulty function of the retinal elements themselves.[3]

Frequently, early in the course of the disease, there may be attacks of hazy and blurred vision which clear up after a period of time. They may be considered due to alteration of the refraction by lens movement.

Rainbow-colored halos around lights are frequently seen by victims of this disease. Such symptoms may be explained as being due to edema of the corneal epithelium caused by water imbibition with subsequent spectral dispersion.

Headache of otherwise inexplicable origin is surprisingly often present in early glaucoma.

Increased intraocular pressure often may readily be recognized by the general practitioner by palpation through the upper lid with the patient's gaze directed downward.

As this insidious process continues, excavation of the optic disk may appear as the tissue of the nerve head is pushed downward in response to the increased intraocular pressure (fig. 5). It must be pointed out, however, that not all cases of glaucoma show this indication to any great extent in time to save the vision.

Loss of side vision occasionally is noted by the patient and may be mentioned to his family doctor. This is due to the previously illustrated peripheral field defects. Chronic glaucoma is almost always bilateral, but both eyes may not be affected simultaneously. One should bear in mind that having any of these symptoms does not necessarily mean that the person has glaucoma. They may also be caused by other less serious eye troubles. On the other hand, these symptoms may not even be present and the patient may still have early glaucoma. If medical care is

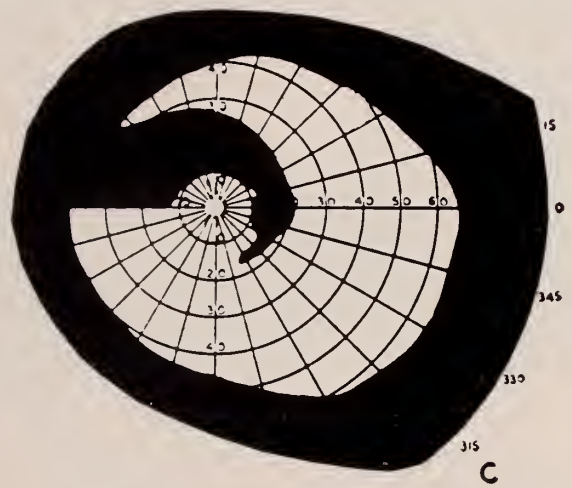


Fig. 3.—Shows further diminution of visual field if pressure is allowed to continue unchanged; right eye. From Evans, J. N.: Classic Characteristics of Defects of Visual Fields, Arch. Ophth. 22:410-431 (Sept.) 1939.

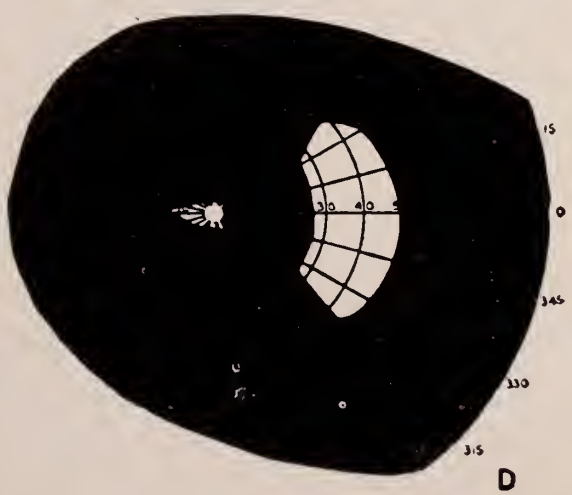


Fig. 4.—Final defect with only a small temporal island of vision left; central fixation lost; right eye. From Evans, J. N.: Classic Characteristics of Defects of Visual Fields, Arch. Opth. 22:410-431 (Sept.) 1939.



Fig. 5. — Shows glaucomatous excavation of optic nerve head. From Payne, B. F.[4]

instituted early, progress of the disease may be stopped, but visual fields once lost can never be restored.

Summary

The general practitioner may find some of the 800,000 victims of glaucoma each year by remembering these early signs, especially in the 40 year and older age groups:

(1) Glasses, even new ones, do not seem to help.
(2) Blurred or hazy vision, which clears up after a time.
(3) Trouble in getting accustomed to a darkened room, such as a motion picture theater.
(4) Rainbow halos around lights.
(5) Repeated headaches, often of mild intensity.
(6) Narrowing of the visual fields.
(7) Increased tactile hardness of the eyeballs, which may be felt through the lid.

All or any of these, when present, may aid in the early diagnosis of glaucoma.

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51 Avista Circle.

Pitfalls in Electrocardiographic Interpretation

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In most medical communities the status of electrocardiography has changed considerably during the past decade. This is particularly true outside of teaching institutions where the trend away from using a central authority to interpret electrocardiograms is probably the result of more thorough training in medical schools and residencies and increasingly simpler technics and reduced overhead with the acceptance of "direct writer" machines. There has been an increase in demand for postgraduate courses in electrocardiography for internists and general practitioners, and an increasing number of practicing physicians prefer to interpret tracings taken on their own patients with occasional assistance from more experienced electrocardiographers. The patient's family physician, fortified by adequate training, is perhaps in a better position to interpret accessory studies than is a stranger to the patient who has a greater knowledge of the disease involved.

Certain problems, however, have accompanied the trend to decentralization of electrocardiography, aided and abetted in part by patients who look to the electrocardiogram as the sine qua non of diagnosis and prognosis of heart disorders past, present and future. The physician should be able to put this notion in proper perspective by emphasizing the nonspecificity of many electrocardiographic abnormalities and the relatively small part the electrocardiogram contributes to the whole, as compared to the careful history and physical examination by a physician who is willing and able to weigh all components before rendering an opinion. This pressure brought to bear by patients is akin to that which insists that any and all complaints must be relieved by an injection of some kind, apparently sometimes to the point of brain-washing the physician into believing it himself.

So with the electrocardiogram which, without other support, proclaims "there is nothing wrong with your heart," or conversely orders a well man to retire because of an electrocardiographic abnormality. The electrocardiogram, as a measure of electrical depolarization and repolarization in the heart, does not necessarily mirror mechanical factors which contribute to its efficiency as a pump. Under these circumstances, of course, the electrocardiogram may be normal under conditions of serious heart disease when the pump is failing, or it may be abnormal in varying degrees in perfectly well, healthy persons.

Overinterpretation

The greatest pitfall in electrocardiographic interpretation is overinterpretation. This is usually fostered by failure to appreciate the limited value of the electrocardiogram and to what extent changes from accepted normal are not of a specific nature. Actually, the only truly specific electrocardiographic abnormalities are found in the relatively small group of arrhythmias and conduction disturbances and perhaps with the classical changes of myocardial infarction. The electrocardiogram may be the only means of distinguishing with certainty between a tachycardia of ventricular and auricular origin, thus being the means of determining which treatment should be given. It is the surest way of confirming a suspicion that the patient with "acute indigestion" actually has had a myocardial infarction, but even here reliability falls off considerably.

Acute myocardial infarction is often a difficult electrocardiographic diagnosis to make with certainty and, in some instances, must be made on the basis of other findings alone, including the history, temperature curve, white blood cell count and serum transaminase. It should be fully realized that a bona fide myocardial infarction may occur without any change being recorded on electrocardiograms taken at the usual intervals. Even when the clinical diagnosis is easily made, the electrocardiographic pattern may be very slow in its appearance and classical evolution, and several days may pass before changes are apparent. A slight flattening or inversion of T waves in only one lead or a change in amplitude of QRS complexes in one lead may have considerable significance in doubtful cases, as might a transient ST segment shift seen on only one of several serial tracings. Infarction involving only the epicardium or subendocardium may present a pitfall in electrocardiographic diagnosis and usually requires supporting evidence before an opinion regarding muscle damage can be given. Posterior or diaphragmatic wall infarction, be-

cause of its location in relation to the standard electrodes, often occurs with minimal or equivalent electrocardiographic changes during the acute phase. The use of esophageal leads and other special technics[1] may be of value.

A point often forgotten but easily demonstrated in serial tracings involves diagnosis of the strictly posterior wall, as distinguished from the diaphragmatic, infarction. The former may produce no changes upon the limb leads, but in serial tracings may increase the R wave amplitude in $V_{1,2,3}$ sufficiently to be diagnostic.

Old, healed myocardial infarction is an important electrocardiographic diagnosis, particularly when, as is often the case, there is no clearcut history of the acute episode. Here again the diaphragmatic or posterior wall location is apt to be a stumbling block. The classical Q_3 and Q_{avF} of at least .04 second width with sharply inverted T waves is the exception rather than the rule. Small Q waves in these leads, with or without T wave changes, cannot be ignored, but must not be overinterpreted. Electrocardiographers often use the phrase, "consistent with but not diagnostic of old posterior wall infarction," when they are not sure of the origin of such patterns. There are other aids in evaluating the electrocardiographic problem of "did or did not this patient have an old posterior wall infarction?" Tracings taken during deep inspiration[2] may alter the heart's relation to the electrodes sufficiently to produce a diagnostic Q wave, which otherwise might have been considered equivocal. Milnor, Genecin, Talbot and Newman[3] presented a method of evaluating the Q_3 and Q_{avF} by determining the direction of the first .02 second of the QRS loop in the sagittal plane, a technic which for the present is not readily available to the majority of electrocardiographers.

The "QS dilemma" is one which often requires examination with a magnifying glass, literally and figuratively. The tiniest "pip" of deflection above the base line may be sufficient evidence to diagnose old infarction if the deflection is at the end of the QS, or, if there is a tiny R deflection at the beginning of the QRS, to enable the electrocardiographer to say unequivocally that there is no evidence of old infarction. Such fine points may be overlooked in a hurried reading

Students or interns sometimes interpret left bundle branch block mistakenly as anterior wall infarction because of the appearance of the precordial QRS complexes. After learning to avoid this error, they may quote an aphorism: "Myocardial infarction cannot be diagnosed in the presence of bundle branch block." This of course is true in some cases, but there are exceptions, to wit: (a) the evolution of fresh infarction can usually be detected by sufficiently frequent serial electrocardiographic tracings during the first few days of hospitalization, as there are usually transient ST and T and/or QRS changes; (b) right bundle branch block seldom interferes with the diagnosis of either fresh or old anterior wall infarction if its pattern is recognized and considered; (c) the presence of a Q deflection in lead 1 or avL in the presence of classical left bundle branch block is evidence of septal infarction, which usually is accompanied by anterior wall infarction. The initial activation of the septum from left to right with the resultant "normal septal Q wave"[4] cannot occur with true left bundle branch block since the septum is then no longer activated from left to right. A Q wave, therefore, indicates that the septum is missing electrically.

Both the effect of digitalis and of "left ventricular strain," the latter usually the result of hypertension or aortic valve disease, may produce a somewhat similar electrocardiographic pattern. This is usually manifested by ST segment depressions in leads 1, 2 avL, V_5 and V_6 and diphasic or inverted T waves in these leads. Broome, Estes and Orgain[5] have outlined a means of distinguishing between these two, based essentially on the shortened QT interval and the shortened T vector which remains unchanged in direction with digitalis effect. Often the ST segment in the presence of digitalis has more the appearance of a thumb impression as seen sagittally than does the pattern of a more variable ST and an often sharply inverted, rather than diphasic, T wave of left ventricular strain. The usual concurrence of left axis deviation with left ventricular strain is helpful. Vector analysis is a useful aid in analyzing and understanding such pattern differences. There is a shortened T vector with unchanged direction with digitalis effect as compared to reversed direction of the T vector in left ventricular strain.

Pitfalls in considering T wave abnormalities in the precordial leads include misinterpretation of the normal juvenile pattern, which consists of inverted T waves in $V_{1,2,3,4}$. This pattern may persist into adult life. The phenomenon of "isolated T wave negativity," which may occur with a normal heart at positions V_4 or V_5 or both can

be clarified by taking multiple precordial leads to pinpoint the area involved.

Serial electrocardiograms are advantageous under several circumstances. Minor changes of QRS and T within the normal range during myocardial infarction, with or without bundle branch block, have been mentioned. During observation with suspected rheumatic fever minor T wave changes or a changing P-R interval within the normal range may be helpful or even pathognomonic. Changes in the corrected QT interval may be of considerable diagnostic importance, particularly in rheumatic fever in which its distinct prolongation may be the only electrocardiographic abnormality. Serial tracings are useful in evaluating changes due to or thought to be due to digitalis effect or electrolyte disturbances.

Right ventricular hypertrophy is often associated with incomplete bundle branch block, but it may at times be represented by pronounced right axis deviation in the limb leads with totally upright complexes and normal interventricular conduction in V_1 and V_2. Left ventricular hypertrophy is more difficult, but is suggested when there is left axis deviation with large upright complexes in leads 1, avL and V_5 and V_6 with large negative complexes in V_2 and V_3.

Pitfalls in the interpretation of arrhythmias are relatively few. An important but rare one is the rapid, fixed tachycardia with wide QRS complexes, apparently of ventricular origin but actually of supraventricular origin with accompanying bundle branch block, the P waves being buried by the preceding complex. A practicable way of distinguishing between the true ventricular and the masked auricular tachycardia is by use of esophageal leads,[6] if such maneuvers as carotid sinus pressure and detection of varying intensity of the first sound fail the examiner. One wonders if those who, contrary to usual teaching, advocate the use of digitalis in the treatment of ventricular tachycardia have in some cases actually been treating supraventricular tachycardia with temporary bundle branch block. A very rapid sinus tachycardia may be confused with paroxysmal auricular tachycardia, although usually the slight variation in rate will distinguish the former. If the patient is at hand, the use of carotid sinus pressure and the history of rapid onset are all that is needed.

In both first degree AV block and supraventricular tachycardia P waves may be hidden, usually in the preceding T waves. Varying amplitudes and configuration, particularly notching, of the T waves may be the key to hidden auricular activity. Here again the esophageal leads may solve the problem by demonstrating well defined P waves.

Lesser Pitfalls

Three relatively minor pitfalls which may mislead the less experienced electrocardiographer are the auricular T wave, the U wave and the phenomenon of ST segment elevation, occurring normally, usually in young persons, most often in the first three or four precordial leads, referred to as "normal early repolarization." When early repolarization is present in young persons in instances of suspected benign or rheumatic pericarditis, serial tracings should demonstrate a slow evolutionary pattern with pericarditis but not with the "normal early repolarization." The auricular T wave is opposite in direction to the P wave and usually is buried in the QRS. With a long or short P-R interval, it may appear as an apparent ST segment shift occurring before or after the QRS, or it may alter the contour of the QRS. Little significance is otherwise attached to the auricular repolarization process. It is remarkable that this phenomenon so seldom interferes with electrocardiographic interpretation. The U wave may obscure the preceding T or following P wave and therefore may cause erroneous calculations of the QT or P-R intervals. This is a pitfall to be considered when electrolyte disturbances or rheumatic fever is suspected.

The electrocardiographer should be aware of faults in technic during the taking of electrocardiograms which might significantly alter tracings. At least once in every technician's career comes the embarrassing mistake of unintentionally reversing the arm leads, causing the physician to believe he has a true dextrocardia, that is, until he examines the precordial leads and finds them in order. Another occasional error in technic involves the smearing of paste between precordial leads, an act that tends to give a sameness to the six precordial leads which would not occur with proper preparation. A remarkable sameness in precordial tracings is also noted when the lead selector is not moved from avF as these leads are taken. Unintentional turning of the standardization switch may produce low voltage as a technical error. When taking serial tracings, one must place the precordial electrodes in exactly the same position from tracing to tracing; other-

wise, changes in the form of the QRS and T waves cannot be adequately compared.

Large breasts, pronounced sternal depression, pneumonectomy, pneumothorax, hydrothorax and emphysema may alter the relation of the heart to the electrodes sufficiently to produce an electrocardiographic abnormality in a normal heart. Such anatomic variations should be noted on the request slip if the tracing is to be read by a person who does not know the patient.

Hyperventilation, fright and exercise can alter the rate and T wave configuration in normal hearts and may pose a problem in differentiation from underlying coronary heart disease. Sedation, reassurance and a comfortable position help to standardize the resting tracing, which should then be compared with a tracing after a calculated amount of exercise when coronary disease is suspected and cannot be diagnosed by the history or resting tracing. Digitalis, adrenalin and atropine are commonly used drugs which may alter the electrocardiogram and mislead an interpreter who is unaware of their effect. The electrocardiogram after exercise cannot be interpreted satisfactorily when digitalis is present in the heart muscle, since RST segment and T wave changes may occur as the result of digitalis effect alone.

Summary

Considerable information is available regarding the normal and abnormal electrocardiogram for the benefit of the increasing number of physicians who interpret their own tracings. Most electrocardiograms do not follow a "text book pattern," and there are many situations which may pose problems to the electrocardiographer. Some of these pitfalls are presented and discussed, roughly in order of frequency of occurrence and importance.

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Organization of a National Streptococcal Epidemiologic Survey

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In 1950, Saslaw, Ross and Dobrin reported the finding of five children with established rheumatic heart disease among 1,001 students in the 12 to 15 year age group born in Dade County. This prevalence rate was lower than most reports from other parts of the United States. Because the group A beta hemolytic streptococcus is considered to be etiologically related to rheumatic fever, a study of incidence, prevalence and behavior of these organisms was instituted in 1952. Search of the medical literature failed to reveal adequate comparative data from other investigative centers. To make our Miami results more meaningful, therefore, other likely workers in the streptococcus-rheumatic fever field were questioned as to their willingness to participate in a joint study. Though affirmative replies were common, funds were not available, so that the years 1952-1955 passed with work carried out in Dade County alone, and with correspondence elsewhere.

Late in 1955, during a conversation with U. S. Public Health Service officials, interest in a cooperative study was elicited. A tentative plan and a rough protocol were drawn up, and a number of investigators were contacted for an expression of interest in the project, if funds could be made available. A minimum of six sites was considered essential for evaluation of climatic effects on beta hemolytic streptoccci and on rheumatic fever. Contact was made with about 15 people, recognizing that only six might be interested. Each area was chosen because of size and climate represented. For purposes of comparison, cities whose metropolitan population ranged between one-fourth and three-fourths million population were sought. Cities of this magnitude would provide adequate groups of children of appropriate ages, adequate numbers of practicing physicians, adequate numbers of schools, and areas representing different economic levels. Many cities selected also contained minority racial groups.

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Supported in part by a U. S. Public Health Service grant H-2628.

Read before the Florida Health Officers' Society, Hollywood, May 5, 1957.

Climatic Factor

The factor of climate created greatest concern, since the variations in the United States are innumerable when temperature, rainfall and altitude alone are considered. Miami was considered essential since climatologically it is the only area in the United States which meets the standards set for tropical climates. According to geographers who follow Köppen's classification, a tropical climate is one in which the average temperature over a period of years, for the month of lowest average temperature, is 64.4 F. or above. An area along the Eastern seaboard (in our case, New Hyde Park, Long Island) provided a mesothermal marine climate for comparison. A humid subtropical climate characterizes almost half the area of the United States, and Nashville, Tenn. is near the center of this belt. Phoenix, Ariz. typifies the American desert, with an average summer temperature of 87 F. (maximum 119 F.), and a winter level of 53 F. The average annual rainfall is 7.5 inches. For Miami, the average annual precipitation is 47.2 inches. Another reason for extending our studies to Phoenix is the reported low prevalence of rheumatic heart disease in that city.

In contrast to Phoenix is Salt Lake City, Utah, where the highest prevalence rate for rheumatic heart disease in the United States has been reported. Salt Lake City at an elevation of 4,305 feet has average temperatures of 32 F. in winter (-20 F. absolute minimum) and 73 F. in summer; average precipitation is 16.3 inches, twice that of Phoenix.

The Pacific coast, with its cool maritime weather, characteristic of the area from Alaska to Southern California, is represented by Seattle, Wash.

Cold winters and cool summers prevail in Montreal, Canada, and the changeable weather of the Great Lakes area in Winnetka, Ill.

Additional climatic types are to be found in Galveston, Texas, and St. Louis, Mo., Anchorage, Alaska, and the Canal Zone, Isthmus of Panama. Contact with these areas has been established, but the advisability of starting the project with a

reasonably small number of sites led us to hold final incorporation of these cities in abeyance.

The Canal Zone is a most interesting site. Since this region is owned and operated in toto by the U. S. government, the entire population consists of middle income workers, living under highly sanitary conditions, enjoying all the needs and many of the luxuries of man. Across the street, in the Republic of Panama, subjected to the identical climatic environment, are people who fall almost entirely into two major groups, one extremely wealthy and the other extremely poor. Sanitation, formerly a function of the U. S. government, is now entirely in the hands of the Panamanians. The meticulous attention to the problems of health no longer exists. Thus, in one small area, in the same climate, three economic classes of people could be studied simultaneously. Unfortunately, due to the rigid control of funds and activities of the Canal Zone by the U. S. government, we have been unable to present as yet a tenable method of including Panama in our study. This problem is still under consideration.

Interest Grows

With the widespread interest shown in a cooperative streptococcal epidemiologic survey, and the associated rheumatic fever data that could be collected, we were prompted to request U. S. Public Health Service extramural support for the organization of a national project. After negotiation, this request was granted in January 1957.

Immediately, each of the possible participants was resurveyed as to his continued interest. Those who responded affirmatively were visited personally in the same month. At that time, a brief provisional protocol was distributed to each potential site leader. The program was discussed, and questions were answered. All suggestions were carefully recorded. The investigators were requested to write their opinions and comments within a month. When all letters were received, the protocol was revised, and redistributed on March 6.

Dr. Albert V. Hardy, Director of Laboratories of the Florida State Board of Health, was asked to join the program by establishing the Miami Branch Laboratory as the streptococcal grouping and typing laboratory, and as the place for performing all antistreptolysin O titrations for all participants. Financing this portion of the project would be by an individual grant from the U. S. Public Health Service. Dr. Hardy agreed.

Dr. Benedict Massell, Research Director, House of the Good Samaritan, Boston, Mass., will serve as coordinator for the study of prevalence of rheumatic heart disease in children living in the participating areas.

Another problem is the supply of adequate quantities of streptococcal typing serums. Grouping serums are available commercially, but typing serums can be obtained only from the Communicable Disease Center of the United States Public Health Service. Again because of financial regulations, we cannot reimburse the Communicable Disease Center directly for the increased load of work entailed by the large scale production of serums. Solution to this phase of supply was approval by the U. S. Public Health Service to employ a technician from grant funds to work with Dr. Elaine Updyke at the Communicable Disease Center.

Consultants were appointed in the fields of bacteriology (Dr. Updyke), epidemiology (Drs. Alexander Langmuir, H. F. Dodge and Simon Doff), climatology (Leonard Pardue), and a clinical rheumatologist (Dr. Massell). The scope of consultation will be broadened to include a biostatistician.

Full information on the total program has been made available to the American Heart Association. Interest and indirect assistance from this group are anticipated. Financial aid has been requested from state heart associations in each of the states in which participation is contemplated. At the moment, commitments for support have been obtained from the Ottawa Laboratory of Hygiene and from the Florida Heart Association. Additional Heart Associations probably will aid. Such aid may be small in amount, but represents the breadth of interest in the investigation.

With all this preliminary work done, the final protocol must be ratified, and all participants must commit themselves definitely. To ensure complete understanding and rapport, a conference has been arranged, to allow full discussion of all aspects of the program. The extent to which other ancillary studies will be implemented—case registry of rheumatic fever and glomerulonephritis, efficacy of penicillin prophylaxis in eradicating beta hemolytic streptococci from the throats of rheumatic children, investigation of prevalence of rheumatic heart disease in school children, and frequency of observation of rheumatic heart disease at autopsy—must be considered.

The conference to make these final decisions starts tomorrow morning and will continue for three days, May sixth through the eighth.

Summary

In the organization of the present national epidemiologic streptococcal study, a problem of national scope was recognized, the problem of defining the incidence and prevalence of beta hemolytic streptococcal carrier states and infections in relation to rheumatic fever. The hypothesis was adopted that these incidence and prevalence rates are influenced by climate. A plan was devised for collecting data adequate to permit evaluation of the hypothesis. Results of the present investigation are expected to lead to new approaches in the study of etiology, pathogenesis and control of streptococcal infections and rheumatic fever.

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The Relationship of Sex to Childhood Accidents

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In 1954 Sowder[1] asked the question, "Why is the sex difference in mortality increasing?" He suggested that "something" other than a basic biologic difference between the sexes accounts in part for the higher mortality among men.

Bowerman[2] of the New York Life Insurance Company was of the opinion that increased mortality rates of the male in late childhood and early adult life are due to greater environmental hazards and the greater ability of the female to adapt to cultural changes. Sowder and Bond[3] voiced their agreement with this conclusion.

It is now an accepted fact that accidents occur more frequently in the male child than in the female. Jacobziner, Heely and Rich[4] reported a sex incidence of 61 per cent male and 39 per cent female. Rice, Starbuck and Reed[5] reported similar figures, 60.5 per cent male and 39.5 per cent female. Bain[6] in her report of accidental poisoning in children gave a sex ratio of 3:2 both for the United States and Britain.

In an attempt to learn more about the "something" to which Dr. Sowder referred, a survey was made of 1,168 accidents in children under 16 years of age treated in the accident rooms of local hospitals. This study also revealed a significant sex difference—738, or 63 per cent, occurred in the male and 430, or 37 per cent, in the female (fig. 1).

The accidents were classified into 10 main groups, listed in the order of frequency of occurrence: Laceration and Contusion, Fracture, Burn, Puncture, Foreign Body, Animal Bites, Poison, Concussion, Sprain, and Dislocation. The only types of accidents in which males did not outnumber females were sprains and dislocations (fig. 2). There may be some relationship here to the type of musculature of the female. There seemed to be no one age group in which females outnumbered the males. There was no significant difference in sex ratio under one year. Accidents occurred more frequently in the three to four year age group.

In a special survey of 66 cases of accidental poisoning in children under six years of age, it was found that 60.6 per cent of the poisonings occurred in males and 39.4 per cent in females. The public health nurses visited the homes of 57 of the patients in these cases to investigate the circumstances surrounding the poisoning. They found that in 58 per cent of the cases the material ingested had been moved from its regular storage place by an adult and left within easy reach of the children.

In 75 per cent of the cases it was not necessary for the children to climb to reach to the poisonous material.

There seemed to be no sex relationship with regard to which children climbed in order to gain access to the poison, as 22.5 per cent of the males climbed and 19 per cent of the females climbed. The difference of 3.5 per cent here is certainly not indicative of any greater curiosity or increased physical activity on the part of the male which would account for increased incidence of poisoning in males. I realize, however, that this may be due to the small number of cases in this special survey and consequently inconclusive.

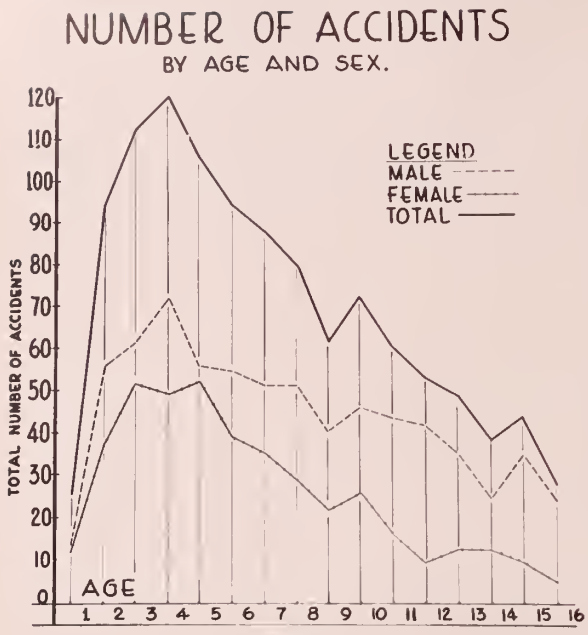


Figure 1

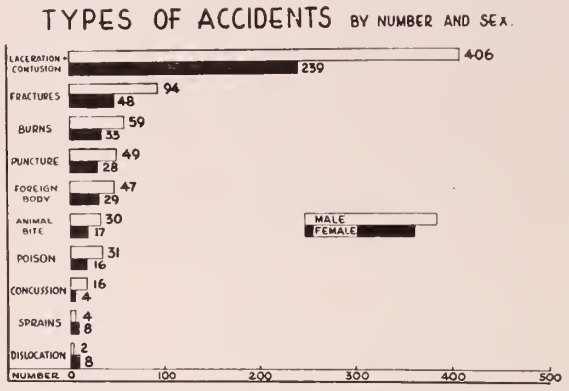


Figure 2

Discussion

Why do accidents more frequently involve the male child? Perhaps the answer to this question, and the resultant prevention of accidents, lies in the answer to other questions.

Is it because of greater physical activity, greater natural curiosity and daring? Is it because as imitators boys attempt to mimic the activity of their fathers?

Is there a difference in the parent's attitude toward a boy baby and a girl baby? Are parents less solicitous, less protective towards their male children?

Do they permit boys to attempt feats which would ordinarily be considered too dangerous or too difficult for girls? Are they sometimes misled by the greater stature of boys and allow them to fend for themselves unsupervised in situations where they lack sufficient judgment and coordination for the task before them?

Do girls have more rest and care during a minor illness and longer periods of absence from school while recuperating?

Does the type of toy which parents select for boys affect the incidence of accidents? When they buy bows and arrows or firearms for boys, do they insist that they use them only in a protected area at a specific target, or do they allow them to roam the neighborhood with these instruments at will?

I have noted a "resigned" attitude adopted by some parents towards the type of games which boys play. I have seen them permit unrestricted "sword fight" play with pointed sticks and have watched them sit idly by while boys climbed onto obviously perilous places and dismiss the situation with a shrug and a comment, "Boys will be boys." It would seem to me that if one accepts the fact that boys evidence greater physical activity or daring, then there is a greater responsibility to supervise their activity and the objects which they utilize during play. Surely one cannot keep a boy from climbing, but one can and should teach him how to climb safely and how to check for stability the object which he plans to climb. One cannot keep him from throwing rocks, but one can teach him not to throw rocks at another boy.

If boys tend to be more "daring," are they seeking recognition in a society which demands too much of them—expects them to be "tough?" How frequently a parent says to a child who has been hurt, "Stop crying! Do you want people to think you're a sissy?"—as if to feel pain were a sign of disgrace. When such an attitude is adopted in the child's infancy, it is a natural sequence to demand much more of men as adults. Perhaps parents really need to check their attitudes. Perhaps they expect too much of "The Fragile Male."

I desire to express my appreciation to Dr. James O. Bond, Mrs. H. H. Stanley and the record librarians of the three hospitals for their valuable assistance in the preparation of this paper.

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ABSTRACTS

Side Lights on Treatment of Dermatologic Diseases of Children. By Morris Waisman. Postgrad. Med. 21:118-123 (Feb.) 1957.

In this article Dr. Waisman outlines some of the standard procedures that have been crystallized from the experience of his dermatologic practice and that of his contemporaries and from the experience of his teachers and their contemporaries. After reviewing a considerable number of therapeutic tools, he offers a half score of random therapeutic observations, general and specific:

1. Good dermatologic treatment is simple, and it should be kept simple. 2. Soap and hot water are almost invariably deleterious to the healing of an eczematoid eruption of the skin. 3. Strong sunshine in the summertime usually is harmful to an eruption, because of the damaging effects of both ultraviolet light and sweating produced by heat. 4. Attention to nutritional requirements should not fail to recognize the desirability of reducing free sugars in the diet of patients who have bacterial and fungous infections of the skin. 5. Physical activity must be restricted in all cases of eruption, and especially in cases of prickly heat and intertrigo. 6. Clothing must be recognized as a possible source of injury, apart from its dyes. 7. The more specific eruptions a physician is able to identify, the fewer become the number of vitamin deficiency diseases he will diagnose. Genuine dermatologic evidence of vitamin deficiency is rare in private practice. 8. Provision for adequate hours of rest may be all that is necessary to keep an annoying eruption of childhood atopic dermatitis under control. 9. X-ray therapy for eczematoid dermatoses in children is never indicated. 10. Time is the essential ingredient of successful dermatologic therapy. Impatience accounts for more failures than improper medication.

Squamous-Cell Carcinoma of the Uterine Cervix. A Histochemical Review. By Alvan G. Foraker, M.D., and Sam W. Denham, M.D. Am. J. Obst. & Gynec. 74:13-24 (July) 1957.

As part of a continuing study of squamous cells of the uterine cervix, tissue from 72 examples of invasive squamous cell carcinoma were subjected to a battery of histochemical technics, including localization of dehydrogenase, alkaline phosphatase, phosphamidase, protein-bound sulfhydryl and disulfide groups, glycogen, and lipid. Comparisons were made with 68 other cervical biopsies. In general, squamous cell carcinoma showed a reaction pattern similar to that of the basal layer of portio vaginalis mucosa, including evidence of dehydrogenase and phosphamidase activity. Keratinizing squamous cells from neoplastic and nonneoplastic epithelium contained disulfide groups. Squamous cells in superficial layers of squamous mucosa and well differentiated squamous carcinoma cells in some cases contained glycogen. No histochemical reaction pattern peculiar to carcinoma was found. These findings are consistent with previous histochemical and physical measurement studies, in which growing squamous cells had essentially similar properties, whether they came from carcinoma or from regions of nonneoplastic proliferation.

Lobotomy of the Dorsal Medial Quadrant for Intractable Pain. By Richard E. Strain, M.D., and Irwin Perlmutter, M.D. South. M. J. 50:796-798 (June) 1957.

In this article, the authors observe that lobotomy for intractable pain has a limited but definite place in the surgical treatment of pain. They believe that it should be reserved primarily for patients with metastatic malignant disease and confirmed addiction who cannot be relieved by other surgical measures. They present a small series of cases in which upper dorsal medial quadrant lobotomy, with its ease of approach and less extensive destruction of tissue, relieved pain and addiction in a manner similar to more extensive medial lobotomies. Their technic is described, and illustrative cases are summarized.

Study of Respiratory Liver Metabolism in Surgical Patients. By H. Clinton Davis, M.D., Irwin S. Morse, M.D., Edward Larson, Ph.D., and Mark Wynn, M.S. J. A. M. A. 162: 561-563 (Oct. 6) 1956.

Direct physiologic tests on liver tissue have been used for many years in experimental work on small animals, but relatively little work has been done on the respiratory metabolism of the human liver. The frequency with which liver biopsy specimens are taken at the operating table for pathologic examination, and the benignity of the procedure, prompted these authors to send a portion of their specimens to both the pathologist and the physiologist. To their knowledge, when the study was started in 1952, oxygen quotient studies had never been reported on human liver.

Liver succinoxidase, oxygen-quotient (QO_2) determinations were made on 10 patients undergoing surgery for gallbladder, colon, or pancreatic disease or peptic ulcer. Values suggested slight impairment of in vitro activity of the enzyme system in the presence of obstructive jaundice in comparison to apparently normal liver. The concept of performing direct physiologic studies on human tissue is believed to be of possible value just as it has been in laboratory animals. It is suggested that the clinical physiologist could well fill some of the gaps in the understanding and assessment of problems of altered metabolism.

Nutritional Management in Duodenal Fistula. By Donald W. Smith, M.D., F.A.C.S., and Robert M. Lee, M.D., F.A.C.S. Surg. Gynec & Obst. 103:666-672 (Dec.) 1956.

The authors present the present status of duodenal fistulas and discuss the immediate and contributing causes of this complication which follows approximately 2 per cent of all gastrectomies and results in 16.5 to 85 per cent mortality, varying with the promptness of diagnosis. They emphasize protein depletion and fluid and electrolyte losses as the most important factors in the pathologic physiology of the patient with a duodenal fistula.

The treatment regimen outlined consists principally of continuous nasojejunal drip feeding of high protein, high calorie solutions through a fine plastic feeding catheter 24 hours each day and continuously until the fistula closes. Vitamins, antibiotics, sump drainage, and skin care about the fistula opening are discussed. The method of nasojejunal intubation in gastrectomized patients is described.

A series of 11 cases in which duodenal fistulas were treated by this method is reported, and five cases are described. In all of the cases the patient survived, and the fistula closed in from seven to 28 days.

Controllable Tube Splint for Choledochoduodenal Anastomosis in Congenital Extrahepatic Biliary Atresia. By H. Clinton Davis, M.D. Am. Surgeon 23:298-300 (March) 1957.

Observing that surgical exploration offers the only hope for those infants with mechanical obstructive jaundice who do not respond to cholagogues, the author describes some of the contingencies that may be encountered. In the more favorable case of atresia, he comments, biliary-intestinal continuity can be satisfactorily established by anastomosing the common duct, hepatic duct or gallbladder to the duodenum, jejunum or stomach. The procedure of choice is anastomosis of the duct to the duodenum whenever possible, securing an adequate anastomotic lumen by suturing the duct to bowel over a short length of No. 8 or No. 10 rubber catheter. The desirability of controlling the anastomotic rubber tube splint has led to the idea of using the tip of the nasogastric catheter, which is routinely placed in the stomach. This tube can easily be passed from the stomach into the duodenum and incorporated in the choledochoduodenal anastomosis. Several small holes are made on the intragastric portion for gastric suction in the immediate postoperative period. The catheter may be pulled up into the stomach and out of the anastomosis at the will of the surgeon. It is suggested that this procedure, which has been successfully performed on dogs, would appear to be worthy of clinical trial.

Use of Relaxin in the Treatment of Scleroderma. By Gus G. Casten, M.D., and Robert J. Boucek, M.D. J. A. M. A. 166:319-324 (Jan. 25) 1958.

No consistently successful therapy has been reported for scleroderma, a chronic disease of unknown cause associated with remissions and relapses. The experience of the authors with relaxin therapy indicates that this treatment influences to a significant degree certain distressing features of scleroderma and therein represents a noteworthy therapeutic advance. Parenteral injection of relaxin was used for periods of from six to 30 months in the treatment of 23 patients with this disease. The degree of improvement noted varied considerably, but several patients were sufficiently benefited to enable them to return to gainful occupation. The most striking results were relief of vasospasm, healing of trophic ulceration, and increase in skin elasticity. Other manifestations of the disease were not appreciably improved by relaxin therapy. No toxic or undesirable side effects were observed.

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The Journal

of the

Florida Medical Association

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JERE WRIGHT ANNIS, M.D.
President 1958-1959
Florida Medical Association

Jere Wright Annis, M.D., President

A native of Minnesota, Dr. Jere Wright Annis was born in Minneapolis on April 30, 1909. He attended Phillips Academy, Andover, Mass., from 1922 to 1926, Dartmouth College from 1926 to 1928, and Cornell College in Iowa for the last two years of his academic training, receiving the A.B. degree from that institution in 1930. Returning to Minnesota for his medical training, he entered the University of Minnesota Medical School, where he received the M.D. degree in 1934. After serving an internship at the Minneapolis General Hospital, he spent three years as a fellow in internal medicine at the Mayo Clinic.

Since 1938, Dr. Annis has been associated with the Watson Clinic in Lakeland, except for five years spent in military service during World War II. He entered the Army Medical Corps in 1941 and was discharged in 1946 with the rank of lieutenant colonel. Locally, Dr. Annis has been on the staff of Morrell Memorial Hospital through the years, serving as secretary and as president, and has held many civic posts. He has been active in the Lakeland Chamber of Commerce, holding several offices and serving as vice president in 1957. A trustee of the Polk County Guidance Center, he is chairman of the Health and Safety Committee of the district Boy Scouts organization and is advisor to the Lakeland Chapter of the American Red Cross and the Lakeland Boys Club. He is medical director of the Polk County unit of Florida Civil Defense. A thirty-second degree Scottish Rite Mason, he is also a member of the Lakeland Elks Club, Yacht Club and American Legion. He holds membership in the Lakeland and Winter Haven Rifle clubs and in the National Rifle Association and the West Coast Pistol League.

Dr. Annis is a past president of the Polk County Medical Association, and also a former secretary and trustee. For many years he has served his county medical society as a delegate to the Florida Medical Association.

Active in the Florida Medical Association for two decades, Dr. Annis has held numerous key positions. He is a former chairman of the Committee on Scientific Work and the Committee on Nursing, has represented the Association on the Advisory Board on Practical Nurse Education of the State Board of Education, and has been a member of the original Committee on Civilian Medical Care for Military Dependents. He has served on the Board of Governors, on reference committees of the House of Delegates for several years, and during 1957-1958 as President-Elect. Also, he has held the post of Associate Editor of The Journal.

A former secretary and past president of the Florida Heart Association, Dr. Annis now serves on its board of directors. He is a member of the West Coast Academy of Medicine and the Florida Society of Internal Medicine, and has served as chairman of the membership committee of the latter organization. He is on the Florida State Hospital Advisory Council and a director and member of the executive committee of Blue Shield of Florida, Inc. In addition, he is a director of the Tampa Regional Mental Hygiene Committee and district chairman of the Florida Medical Committee for Better Government. His membership in the Florida Historical Society bespeaks his interest in Florida history. He is also a member of the Sons of the American Revolution.

Among the national medical organizations with which Dr. Annis is affiliated are the American Medical Association, Southern Medical Association, American College of Physicians, American College of Cardiology, American Heart Association, Association of American Physicians and Surgeons, American Gastroscopic Society, Alumni Association of the Mayo Foundation, and the World Medical Association. He is a diplomate of the American Board of Internal Medicine.

A contributor to medical literature, Dr. Annis is the author of a number of professional papers on various subjects pertaining to his specialty. He served as a collaborating editor of "The Book of Health," published by the Elsevier Press in 1953.

Dr. Annis and Mrs. Annis, the former Miss Margaret Tinkham of Iowa, have two sons and two daughters, Jere W. III, Mary, Michael and Kathryn.

PRESIDENT'S PAGE

1958-1959 Objectives

GREETINGS—TO ALL 3,349 OF YOU WHO ARE THE FLORIDA MEDICAL ASSOCIATION:

We, your new officers, reaffirm our resolutions, plans and objectives for the coming year. We hope and pray that our industry and zeal may balance our inadequacies and we pledge you our best.

The year ahead is an important one and in it we will face many problems—some old and some new. We must change with the times, adjusting and modifying our concepts and practices to keep abreast of a rapidly changing world—but preserving the basic ideals and principles of our profession, and striving always to maintain its proper dignity and respect. The responsibility of our great professional tradition is a heavy and a hallowed one.

During this year we will finish the revision of our Constitution and By-Laws and present them for your approval at the House of Delegates next May. Furthermore, we will complete and distribute a handbook for county officers to aid in their orientation in the Association's affairs.

Our Legislative Committee will remain active and alert, endorsing such legislation as is sound medically, and opposing that which is not.

Through our own Association, and through the Governor's Advisory Committee, we intend to study the medical care for the indigent problem in this state, and to know more about it than anyone else. We intend to integrate this with the problem of total medical care, rather than with the problem of indigency—for we think this is where it belongs—and we hope to propose a carefully weighed and considered program for its solution.

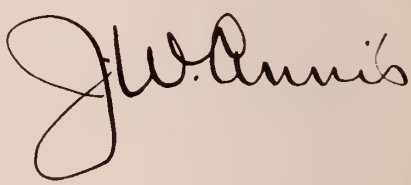
We will continue our attempts to solve more adequately the Medicare problem and re-evaluate our contract with the government.

We will follow the instructions of the House of Delegates in following through on the Blue Shield program.

Designated physicians will again meet with our senators and representatives in Washington to discharge our obligation in voicing our views on national affairs.

All these tasks—and many more—we shall undertake on your behalf to the best of our ability, and on their progress we shall attempt to keep you currently informed through the pages of this—your Journal.

Please give us your criticism—your advice and your help—by attending your county Association's meetings, serving on its committees and helping intelligently to formulate and voice its sentiments and policies. Help us, too, by taking an active part in the affairs of your community—by being a good citizen as well as a good doctor. This, more than anything else, will make our public relations program a success.



THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. Box 2411 Jacksonville, Florida

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Whither Goest?

More than a dozen years ago, the writer sat with a panel which was a part of the instructional program for sophomore medical students. It was not so much the purpose of the panel to resolve problems as to present them for discussion and reflection. On the particular occasion, the subject was the potential danger of the indiscriminate use of the sulfonamides and the new antibiotic, penicillin.

In recalling the tenor of the panel's discussions, predictions were made which now are realities; and certain observations as to the role of the public's demands in the determination of medical practices are, today, more disturbing than then. Two facets of the discussions having interrelationships are interesting to contemplate and may, perhaps, stimulate some thought albeit the outcome of such thought cannot be ventured now.

The time of the discussion was not long after penicillin had been made available to physicians and already certain defects in the interaction between the agent and the organisms against which it was so potently active were being noticed. Similar observations had been noted in the use of the sulfonamides. It was observed that some infectious agents, and among them the staphylococci in particular, possessed capabilities of rapidly developing permanent resistance to the effect of the new antibiotics, such characteristic being passed from generation to generation of organisms. Although the observation held interest to the bacteriologist as exemplifying the adaptive ability of micro-organisms in unfavorable environments, it carried a greater and obvious impact for the physician and patient. Pleas were made to the profession not to use the sulfonamides and penicillin indiscriminately but to be certain of the effectiveness of these agents on the causal agent of infection at hand and then to use them with a heavy hand. Warnings were made also that subeffective doses of the antibiotics were more dangerous than none at all, for the use of such amounts could lead to the acclimatizing of the causal organisms in such a manner as to bring about the development of resistance to the antibiotics.

We are now witnessing the results of organisms developing this almost complete resistance to therapeutic agents. At the moment, and in several

different areas, the problem of resistant staphylococci has reached large proportions. This is a tragic situation, but it is more tragic to look into an aspect which, indirectly perhaps, may have led to the predicament.

During the course of the panel discussion mentioned previously, the physician members agreed that care had to be observed in the use of the new therapeutic agents, yet they had been put in a peculiar position through the demands of a public which was only partially informed as to the story of the antibiotics. Writers of articles for popular magazines and the newspapers who were ill-informed or noninformed of the whole picture were playing up the sensational facets of the new "wonder drugs." Patients who previously had little knowledge of the therapeutic armamentarium of Medicine were sensitized, and not in the immunologic sense, to expect miracles from the use of the "wonder drugs" in any ailment. Indeed, patients were diagnosing their own ills before going to the physician and woe betide the physician who disagreed with the diagnosis. The physician who was asked to administer one of the antibiotics could, of course, refuse to do so but only in the certain knowledge that the patient would seek help elsewhere until a sympathetic ear were found.

This activity of popular magazines and newspapers in keeping the public informed, but incompletely so, on the newer developments in Medicine has had other repercussions. Witness, for example, the widespread and indiscriminate use of the tranquilizing agents until now they have become an almost necessary part of diet to many patients with no thought as to eventual effect of prolonged usage. A part of the practice of Medicine has become based on patient demands rather than patient needs, and who is to say where such demands will lead? Medicine is undergoing startling advancements; it also is witnessing the application of the old adage, "Knowledge is dangerous when only small amounts are possessed."

It is too late to remedy the damage which has been done, but is it too late to apply a few preventive measures?

Complete proceedings of the Annual Meeting of the Florida Medical Association held May 10-14 is scheduled for publication in the July issue of The Journal. Because of printing deadlines, it was not possible to publish this material in June.

Phenylpyruvic Oligophrenia

Phenylpyruvic oligophrenia is a syndrome which was described approximately 60 years ago and which recently has interested many research scientists. Recent developments have given much hope for the future of the persons afflicted with this disease. The condition is due to a recessive gene; therefore, several children in the same family may be afflicted.

It is an abnormality of the metabolism of phenylalanine, which is as a rule broken down into several compounds, the principal one of which is tyrosine. This is one of the essential amino acids for the development of nervous tissue. If not properly metabolized, phenylpyruvic acid and other abnormal metabolites are formed in the blood stream and are eliminated through the kidneys. It is thought that several of these abnormal metabolites are toxic to nervous tissue and produce nerve destruction. The syndrome, therefore, is characterized by a poor development of nervous tissue and possible destruction of this tissue.

The children are usually blond, rather low grade mentally, hyperactive, and frequently epileptic. The disease can be diagnosed by acidifying the urine and adding ferric chloride to it. This produces a green color immediately which fades on standing. Many pediatricians now run this test routinely on the wet diapers of infants as a scanning type of detection.

Several state pediatric societies have sponsored programs encouraging pediatricians to carry out this test on children from one to six months of age on routine office check-ups. The Swedish Medical Society and Norwegian Medical Society have both recommended it to their physicians.

Treatment consists of a low phenylalanine, high tyrosine diet until the child's urine becomes negative for phenylpyruvic acid and then the gradual addition of other foods, with low phenylalanine content, until the child is on as normal a diet as possible. This is maintained from one to 10 years, and as a rule the patient develops normally.

Graduate Medical Education Seminars

The Seminar in Internal Medicine held at the College of Medicine of the University of Florida on April 3-5, 1958 was attended by 49 physicians from all parts of the state. The seminar was devoted to selected disorders of the thyroid gland,

the kidneys, and the respiratory system. and the speakers were out of state lecturers and members of the faculty of the College of Medicine. Those in attendance found the subject matter of the talks and discussions both stimulating and of practical import.

Two seminars will be held in the fall of 1958, the dates to be announced later. One will be a seminar in internal medicine devoted to gastrointestinal and hematologic disorders, and the other will be a two and a half day seminar in general surgery.

Medical Lecture Tour to Asia

The Asia-Pacific Academy of Ophthalmology is sponsoring a good will tour to countries of the Orient following the International Congress of Ophthalmology in Brussels in September 1958. The purpose of this tour, which is to last approximately one month, is to hold joint meetings with ophthalmologists in Pakistan, India, Thailand, the Philippines, and Hong Kong. It is expected that this good will tour will create much interest among physicians in the countries to be visited and contribute greatly to American-Asiatic medical rapprochement.

The government has given its wholehearted support to the plan of stimulating and facilitating a continuing exchange of information and technics, treatments and devices for the care of the ill and the blind. The reception of a group of physicians from the West throughout Asia will certainly be most cordial and will assure the success of this enterprise. The ophthalmolgic and medical material in all the countries is extremely interesting and should be of great value to members of the tour.

The Asia-Pacific Academy of Ophthalmology was organized in 1957. Its principal purposes are to extend ophthalmologic knowledge and to advance the arts and sciences of ophthalmology and related sciences in Asia and in countries bordering the Pacific Ocean; . . . to stimulate research in tropical and systemic eye diseases that are particularly prevalent in Asia and in countries bordering the Pacific Ocean; to cultivate social and fraternal relationship of physicians residing in Asia; . . . to offer postgraduate instruction in ophthalmology through the medium of lectures, round-table discussions, seminars, clinics, films and other means.

Physicians other than ophthalmologists and their families are also welcome to join this trip. Those desiring to participate in the postgraduate lectures and seminars on medical subjects pertinent to ophthalmology should contact William John Holmes, M.D., Liason Secretary, Suite 280, Alexander Young Building, Honolulu 13, Hawaii. Inquiries regarding travel arrangements should be sent to Compass Travel Bureau, 55 W. 42nd Street, New York 36, New York.

Sears-Roebuck Foundation Plan For Community Medical Assistance

The Sears-Roebuck Foundation, organized and endowed by Sears, Roebuck and Co. to aid in the economic and social improvement of the American community, works in cooperation with established agencies. Its widely varied projects include programs developed for charitable, scientific and educational purposes. Its Community Medical Assistance Plan, developed with the cooperation of the American Medical Association, represents a recent extension of the work of this nonprofit corporation. This new project designed to assist communities in providing medical facilities is directed toward communities that have no physician and would like to build a facility in order to attract a doctor.

Competent and convenient medical care is the best insurance a community can carry. It demands the services of a well trained physician, the support and cooperation of the community, and modern medical equipment and facilities. Many small communities today are handicapped when competing with cities for the services of doctors and lack the necessary knowledge of how to obtain these services. In their efforts to improve the health of the area they may now turn to the Community Medical Assistance Plan for aid. This educational activity is aimed entirely at providing to the community educational services that will furnish the "know how" and coordinate the efforts of a community in its attempt to attract a doctor. These educational services are prepared to:

1. Assist in a survey of the community to ascertain its ability to support a doctor.
2. Provide the services of a professional economic consultant to aid the community in both organizational and fund-raising activities.
3. Provide architectural services in the form of blueprints and specifications for a med-

ical center or advise on remodeling an existing structure.

4. Utilize the experience and efforts of the American Medical Association, the Medical Advisory Board of the Foundation, and the state medical society in obtaining the doctor.

The preliminary survey provides a factual evaluation of the medical needs of the area. If the survey is favorable, community organization begins with the selection of a committee of leading citizens to initiate the activity and raise the necessary funds. When the funds have been raised, a permanent nonprofit corporation can be established.

Most rural communities have no hospital and probably could not support one. The up-to-date medical facilities required by modern medicine are therefore all the more important in rural areas. It is essential that facilities there include provisions for emergency surgery and one or two recovery beds. The Foundation retains a professional architect who specializes in medical architecture. Plans are now available for a one or two doctor unit that is adaptable to local building materials, is modern in design and contains many built-in features. Complete blueprints and specifications will be given the communities selected. In the event an existing structure could be remodeled and still provide attractive and efficient medical facilities, advice will be given.

The community that provides modern medical facilities increases its competitive position in obtaining a physician. The Foundation has a close working relationship with the American Medical Association and the state medical societies. A 17 member Medical Advisory Board has been appointed by the Trustees of the American Medical Association to advise and cooperate with the Foundation in this medical program. The efforts of all can be combined to encourage competent young physicians to practice in areas participating in the plan.

Persons or groups in Florida who believe that their community could qualify for this self-help program for which the Foundation offers to assist with specialized services may obtain application blanks from the Florida Medical Association Physicians Placement Service, Box 2411, Jacksonville 3, Fla. After the blanks have been completed, they are sent to the Sears Roebuck Foundation, 675 Ponce de Leon Ave., Atlanta, Ga.

Statewide Medico-Legal Institute Well Attended

The third Statewide Medico-Legal Institute, sponsored jointly by the Florida Medical Association and the Florida Bar, was held in Tampa on April 11 and 12, 1958. The registration, which totaled 143 persons, included 117 attorneys and 26 physicians.

Presiding officers for the three sessions were the Hon. Baya M. Harrison Jr. of St. Petersburg, President of the Florida Bar, Judge William P. Allen of the Florida Second District Court of Appeal and Florida Supreme Court Justice Stephen C. O'Connell.

Dr. John E. Gottsch of Tampa and the Hon. Jack F. Wayman of Jacksonville presented the first topic, "Whiplash." The subject of doctors' professional liability was discussed by the Hon. J. Lance Lazonby of Gainesville and the Hon. William A. Gillen of Tampa.

The second session opened with a discussion of "The Doctor's Day in Court" by a panel which consisted of Dr. Ben J. Sheppard of Miami, Dr. Herschel G. Cole of Tampa, the Hon. William M. Berson of Orlando, and the Hon. Edward B. Rood of Tampa. The topic "Post Concussion Syndrome" was discussed by Dr. W. Tracy Haverfield and the Hon. Earl Faircloth, both of Miami. The final subject of the day, "Relationship of Trauma and Strain on the Cardiovascular System," was presented by Dr. Herbert Eichert and the Hon. Kenneth B. Sherouse Jr., both of Miami.

The Saturday morning session opened with a discussion of "Back Injury—Its Cause and Sequelae," presented by Dr. Frank H. Lindeman Jr. and the Hon. T. Paine Kelly Jr., both of Tampa. The final subject, "Disability Evaluation," was discussed by Dr. Earl D. McBride of Oklahoma City, the Hon. C. C. Howell Jr. of Jacksonville and the Hon. C. J. Hardee Jr. of Tampa.

In charge of arrangements for the meeting were Dr. Sheppard, who is chairman of the Florida Bar's Committee on Medicolegal Law and Procedures, and Dr. Haverfield, who is the member of the Florida Medical Association's Public Relations Advisory Committee responsible for liaison with the legal group. Concluding the Friday portion of the program was a social hour and dinner. All sessions were held in the Hillsboro Hotel. Previous Institutes were held during 1957 in Miami and Jacksonville.

1958 State Science Fair

"Along with other members of the Committee, I was amazed at the high caliber of the exhibits which we judged. It was very difficult to select the winners because they all showed evidence of hard work, intelligence and superior ability. We would do well to encourage these youngsters to become members of our profession."

These are the words of one of the physicians who served as a judge for the Association's second annual awards for medical aptitude in the 1958 State Science Fair, held April 10-12 in St. Petersburg at the St. Petersburg Junior College. They typify the reaction of each of the physicians who took part in the judging.

The Florida Medical Association Awards were established in 1957 to recognize the scientific achievements of junior and senior high school students and to encourage promising students to enter various fields of medical science. The awards were presented for the first time in April 1957 at the State Science Fair held at the University of Florida in Gainesville.

In addition to the two top awards of special hand-lettered citations and $75 and $50 in cash for the Science Fair's senior and junior divisions, respectively, the 1958 awards were enhanced by four honorable mention awards presented by the Woman's Auxiliary to the Association. These awards consisted of hand-lettered citations and $25 each in cash.

A total of 42 of the Science Fair's approximately 200 exhibits were judged for medical aptitude by the Association's committee. Each student whose exhibit was judged, whether or not he won an award, received an attractive certificate of recognition from the Association.

The citations which accompanied the two top awards were issued "In commendation of an Exemplary and Original Exhibit in the Field of the Basic Medical Sciences and Health Displayed at the 1958 State Science Fair, Saint Petersburg, Florida." They were signed by the President and Secretary-Treasurer and impressed with the Seal of the Association.

At the awards ceremony on April 12, the Association's senior award went to Bill Nelson of Melbourne High School, Melbourne, for his exhibit entitled "Injecting Genetic Material Into Newborn Mice." Manuel L. Cepeda of Ocala Junior High School, Ocala, won the junior award for his exhibit entitled "Experiment with Vitamin Deficiency." The awards were presented on behalf



Dr. Francis H. Langley, of St. Petersburg, Past President of the Florida Medical Association, congratulates Manuel L. Cepeda (left) of Ocala Junior High School and Bill Nelson of Melbourne High School, junior and senior winners of the Florida Medical Association Awards in the 1958 State Science Fair.

of the Association by Immediate Past President Francis H. Langley of St. Petersburg.

The honorable mention awards were presented on behalf of the Woman's Auxiliary to the Association by Mrs. John P. Ferrell of St. Petersburg, a member of the Board of Directors of the Auxiliary. The winners of these awards in the senior division and the titles of their exhibits were: Suzanne Brown, Melbourne High School, Melbourne, "Antigenic Reactions of the Salivary Gland in Immunity to the Mosquito Bite;" James E. Kutz III, Archbishop Curley High School, Miami, "Glands;" and Frances Kay Woodcock, Melbourne High School, Melbourne, "Hypothalamic Lesions and their Effects on Body Temperature." In the junior division, Barbara Smith of John Gorrie Junior High School, Jacksonville, received an honorable mention award for her exhibit entitled "Medicines Derived from Plants and Animals."

The Association's special judging committee was composed of Dr. John P. Ferrell, Chairman, Dr. Douglas W. Hood, Dr. Donald E. McClanathan, Dr. Frank L. Price and Dr. John P. Rowell, all of St. Petersburg.

Sarasota County Medical Society Employs Executive Secretary



Mrs. Blanck

As reported in the April Journal, four component county medical societies of the Florida Medical Association had a lay executive secretary early this year. Last month another county society was added to the list, and this month a sixth society reports following the popular trend. These organizations are the Dade, Duval, Orange, Pinellas, more recently Broward, and now Sarasota County societies.

Mrs. Eleanor R. Blanck has recently been employed by the Sarasota County Medical Society as Executive Secretary. A native of Montgomery County, Maryland, Mrs. Blanck attended George Washington University, where she was awarded the Bachelor of Arts degree. For several years, she was on the editorial staff of the American Council on Education in Washington, D. C. Prior to filling that post, she attended the conference of the Food and Agriculture Organization of the United Nations at Quebec, Canada, as a part of the Chinese Delegation, and also attended the next conference at Copenhagen, Denmark, as a member of the staff of the Food and Agriculture Organization.

Mrs. Blanck has one son, Bobby, aged seven. She resides in Sarasota.

Southern Postgraduate Seminar Saluda, N. C., July 7-26

The Southern Postgraduate Seminar, formerly the Southern Pediatric Seminar, will hold its thirty-eighth annual session at Saluda, N. C., in July. The program for the first week, July 7 through 12, includes lectures on both Pediatrics and Internal Medicine. The second week, July 14 through 19, is devoted to a series of lectures on Pediatrics, and the program for the third week, July 21 through July 26, covers Obstetrics and Gynecology. The course is a postgraduate seminar presenting the newest methods of diagnosis, prevention, and treatment in these three fields with emphasis on the solution of ordinary daily problems in the most modern, scientific and satisfactory way. It is designed to fit the needs of the general practitioner, and credit for attendance is accepted, hour for hour, Category 1, 35 hours per week, by the American Academy of General Practice.

The lecturers are among the finest medical authorities in the South. The faculty, a happily balanced combination of professors and practitioners, volunteer their services to create a unique teaching center where the most advanced information is presented. Most universities in the South are represented on the faculty, and special guest lecturers join the teaching staff to add freshness and divergent points of view. Florida faculty members include Dr. Warren W. Quillian, of Coral Gables, Dean, Dr. J. Champneys Taylor, of Jacksonville, Dean of Obstetrics, Dr. Robert B. Lawson, of Miami, and Dr. Hugh A. Carithers, of Jacksonville.

Southern Railway Surgeons Annual Meeting Held

On April 14 and 15, the Association of Surgeons of the Southern Railway System held its Fifty-Seventh Annual Meeting in the George Washington Hotel in Jacksonville with 130 doctors attending. These doctors were from all of the Southern States east of the Mississippi River, and from a few of the border states.

Following two days of scientific sessions at the hotel and at the Duval Medical Center, the meeting ended with election of officers for the coming year. Dr. Battle Malone, Memphis, Tenn., succeeds Dr. Cecil E. Newell of Chattanooga, retiring president. Other officers named are Dr. Sam Orr Black Jr., Spartanburg, S. C., first vice president; Dr. Max Rogers, High Point, N. C., second vice president; Dr. Walter R. Brewster, New Orleans, La., third vice president; Dr. Kenneth Morris, Jacksonville, fourth vice president; Dr. J. Marsh Frere Sr., Chattanooga, Tenn., recording secretary; and William J. Ashton, Washington, D. C., secretary-treasurer.

OTHERS ARE SAYING

Will Tragedy Strike?

Every day a dangerous product is being used and sold in our midst with relatively few safeguards. I refer to the insecticides of the Phosphate group and one of this group is known to you as Parathion. There are others of this group with newer ones being developed.

When these poisons were first introduced they were mainly used by the large commercial citrus growers who have learned by hard experience to practice safeguards in their use. They are careful to require protective clothing, frequent blood counts, and then limited exposure for those engaged in the actual spraying operation. Even with these protective measures some serious illnesses still occur.

Parathion can be purchased by any individual at a garden store. However, some stores try to persuade you not to use the product unless you are thoroughly familiar with it and warn you of its danger. There are many commercial sprayers who use this product daily throughout all residential areas of this city. They will suddenly arrive at a home requiring spraying and turn on a high pressure spray that pours out a heavy fog of this lethal agent. I have personally seen them turn the sprays up into the trees when high winds were blowing and this causes the spray to drift over to adjacent homes. Apparently little attempt is made to warn the adjacent homes that spraying is being done and that they should close their windows and protect their children and animals until the spraying is completed.

To carry out commercial spraying, individuals must have a landscaper's license and they are supposed to exercise precaution in the use of Parathion. Apparently those engaged in spraying are not impressed with the dangers of this agent and seem to require no protective clothing, give no warning to adjacent homes that spraying is being carried out, and I am sure do not require blood counts and limited exposure for those actually engaged in spraying. Recently, when a controversy locally arose regarding the use of Parathion, one commercial sprayer was so little impressed with the dangers of this agent that he stated that it was a little more than a good "laxative."

Inhalation alone is not considered important as a cause of serious poisoning but I wonder if this applies to the many persons in our community with chronic pulmonary and cardiac disease. I know of several cases of acute asthma occurring from casual contact with the spray. I know of another case where an individual developed severe swelling about the eyes from contact with bed clothing that had been contaminated by spraying next door. When the person involved asked to be given warning so that they could close the windows to their house when spraying occurred next door, the man in charge of the spraying laughed and continued to use the spray in a very careless manner.

These Phosphate poisons are very toxic agents and I personally feel that they should not be used in residential areas but should be confined to farming and citrus operations where those using these agents have a healthy respect for the dangers involved. I am sure that those individuals over the state who have become poisoned and those doctors who have had to treat poisoning cases feel that Parathion is much more than a "good laxative" and anyone who handles this product, and considers it in this light, has little concept of the danger involved.

Richard L. Foster, M.D.
The Record, Broward County Medical Association
November, 1957.

Organic Phosphate Poisoning

The purpose of this presentation is to call your attention to the dreadful consequences of untreated insecticide organic phosphate poisoning, and to indicate a dermatological sign that may be helpful in suspecting the disease at a stage before serious consequences may result. All too late, we are seeing more and more patients with signs of cardiac arrest, acute abdomen paralysis, convulsions, or coma. Such acutely ill patients may die, often within the hour, and occasionally within ten minutes of the onset of symptoms. To the doctor "on guard," such a patient is treated easily, recovers promptly, and with no after effects. Most certainly, then, it becomes necessary for the welfare of our community that we disseminate full and complete information to all physicians and especially to the emergency room doctors of hospitals.

The organic phosphates responsible for human poisoning are listed below with their common trade names and chemical structure.

1. Parathion—diethyl-p-nitrophenol thiophosphate.
2. Systox—diethoxythiophosphoric ester of 2 ethyl mercaptoethynol.
3. TEPP—tetraethyl pyrophosphate.
4. HETP—hexethyl tetraphosphate.
5. EPN — ethyl-p-nitrophenol-thionobenzenephosphate.
6. OMPA—octamethylpyrorophosphoramide.
7. Malathion—dimethyl S-phosphorodithionate.
8. Diazinone-diethyl-O-thiophosphate.

Most reported fatalities have been from the more commonly used preparations, Parathion and Systox. Diazinone is now on the market and preliminary studies indicate that it is so readily absorbed through skin as to be more toxic to humans than its sister preparations. Malathion exhibits low toxicity as compared to the others.

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In general, the *formulation* consists of 3% sprays and 4% dusts. Aerosols are concentrated to 10%, especially as the Parathion preparation, when used in nurseries and greenhouses. *Exposure* concerns persons engaged in synthesizing, formulating, packaging, applying it, or working among residues. Even occasional exposure may predispose to poisoning. Children exposed to "empty" containers, or open ones, have been a major source of chemical poisoning. The organic phosphates are readily absorbed through the skin. Inhalation alone, is not considered important as a cause of serious poisoning because these compounds have a very low vapor pressure. Ingestion, of course, may be fatal rather promptly. The *mode of action* of these poisons involves inhibition of cholinesterase enzymes of the blood and tissues resulting in release and accumulation of excessive amounts of acetylcholine. Therefore, the resulting *signs and symptoms* are those of marked parasympathetic stimulation. The symptoms include: headache, weakness, nausea, cramps, giddiness, blurred vision, diarrhea, chest discomfort and nervousness. Signs include: sweating, miosis, or paradoxical mydriasis, salivation, tearing, cyanosis, pulmonary edema, muscle twitches, convulsions, coma, areflexia, and loss of sphincteric control. All these changes are reversible with adequate and prompt therapy. The essential *laboratory finding* for diagnosis is the reduction of the cholinesterase level of blood or serum. The *differential diagnosis* runs the gamut of cardiac as well as acute abdominal diseases. Poisonings have been confused with heat stroke, heat exhaustion, gastroenteritis and pneumonia. Mild poisoning must be differentiated from asthma and simple fright. In every case, there is need for a careful history of exposure and a comprehensive analysis of clinical observations. Recently, a 26-year-old fireman was seen complaining of periodic, profuse sweating and roughness of the skin, of three weeks duration. He had been engaged in crop dusting for the past three months. The chemical used was Parathion. Two of his associates had developed nausea and weakness at about the same time. Examination revealed cutis anserina (gooseflesh) of the arms and back manifested by closely set papules surmounted by tiny hairs. Patchy areas of hyperhidrosis were noted on the extensor arms and back. Pupils dilated. The impression diagnostically, was that of Parathion poisoning. The patient recovered when removed from contact with the chemical. It is not known whether the



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foregoing case represents a pathognomonic feature of this disease. However, it is presented with the view in mind that it might be helpful in arriving at a very early conclusion before continued exposure to organic phosphates may lead to serious poisoning.

In the more usual case, where the patient is obviously ill, *therapy* should be instituted at once. One to two mgm (1/60 to 1/30 grains) of atropine sulfate, every hour, is given intravenously up to 20 mgm per day. Although these doses appear excessive, people poisoned by organic phosphates have been noted to have increased tolerance for atropine. The effects of intravenous atropine begin in one to four minutes and are maximal in eight minutes. Atropinization, to a lesser degree, should be maintained in all cases for twenty-four hours, and in severe cases, forty-eight hours. *Never give morphine, theophylene, theophylline-ethylenediamine or intravenous fluids. Do not give atropine to a cyanotic patient.* First, give artificial respiration, then atropine. To relieve pulmonary congestion, postural drainage and suction may be used. When signs and symptoms have been allayed, the patient must be quickly de-contaminated. Wear rubber gloves to remove the patient's clothing. Bathe him with soap and water using baking soda because organic phosphorus compounds are hydrolized more rapidly in the presence of alkalies. If ingestion of the poison is suspected, induce vomiting and give milk or water. Atropine does not protect against muscular weakness. The mechanism of death is respiratory failure. Therefore, the use of positive pressure oxygen should be started early. This acute emergency lasts twenty-four to forty-eight hours, and the patient must be watched continuously. In very severe cases, one must give artificial respiration at once, followed by atropine, 2 mgm intravenously, as soon as cyanosis is overcome. This dose is repeated at five to ten minute intervals until signs of atropinization appear. These are recognized by the dry, blushed skin and a tachycardia near 140 per minute. The skin is then decontaminated or the stomach is emptied, if ingestion has occurred. Symptomatic treatment should follow. It should be noted that quantities of atropine, greater than 3 mgm, given within the first five hours, are likely to revive persons severely poisoned with Parathion.

Recently toxicity classes were established for the various insecticide poisons. Classes 5 and 6,

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labeled as extremely toxic and super-toxic, have been assigned to the organic phosphates. Apparently, organic phosphorous derivatives are poisons of the first magnitude and must be treated with caution by all who are exposed to them.

In view of the foregoing, and the increasing number of fatalities reported about the nation, it may well be that medical societies, individually or collectively, may express interest in seeking legislation for the control of these highly dangerous poisons to which human beings, innocently and even unknowingly, are being exposed to daily.

Tobias R. Funt, M.D.
The Record, Broward County Medical Association
November, 1957.

American Medical Association Annual Meeting

The 107th Annual Meeting of the American Medical Association opens June 23 in San Francisco and continues through June 27. The Sheraton-Palace Hotel will be headquarters for the sessions of the House of Delegates.

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STATE NEWS ITEMS

The American College of Gastroenterology has announced that its annual course in postgraduate gastroenterology will be held at the Jung Hotel in New Orleans October 23-25. The course will be under the direction of Dr. Owen H. Wangensteen, Professor of Surgery at the University of Minnesota Medical School, and Dr. I. Snapper, Director of Medical Education, Beth-El Hospital, Brooklyn, N. Y. They will be assisted by a faculty selected from the medical schools in and around New Orleans. Information may be obtained from the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

The American Physicians Fellowship for the Israel Medical Association is sponsoring a tour to Israel for the 4th World Medical Assembly of the Israel Medical Association. The Assembly is being held in Tel Aviv, Haifa, Jerusalem, August 12-24. Tour group will depart from New York on August 9 and will leave Israel on August 24. Details may be obtained from American Physicians Fellowship, 1330 Beacon Street, Brookline 46, Mass.

Drs. Maurice Kovnat of Lantana, and Louis G. Lytton of Miami Beach are members of the Executive Committee of the American organization.

The Seventh Annual Symposium for General Practitioners on Tuberculosis and Other Chronic Pulmonary Diseases is being held in Saranac Lake, New York, July 7-11. Dr. Henry W. Leetch, P. O. Box 627, Saranac Lake, N. Y., is general chairman.

The Second Oklahoma Colloquy on Advances in Medicine has been scheduled for November 12-15 at the University of Oklahoma School of Medicine, Oklahoma City. It will be devoted to arthritis and related disorders and is under the joint sponsorship of the Department of Medicine, University of Oklahoma; the Division of Postgraduate Education; Geigy Pharmaceuticals; Wyeth Laboratories; the Upjohn Co.; Pfizer Laboratories, and the Schering Corp. Information may be obtained by contacting the Division of Postgraduate Education, University of Oklahoma School of Medicine, Oklahoma City.

(Continued on page 1376)

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Riseman, J. E. F., Altman, G. E., and Koretsky, S.: Nitroglycerin and Other Nitrites in the Treatment of Angina Pectoris. Circulation (Jan.) 1958.

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*Reports to the Squibb Institute for Medical Research

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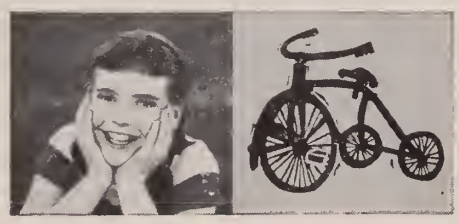
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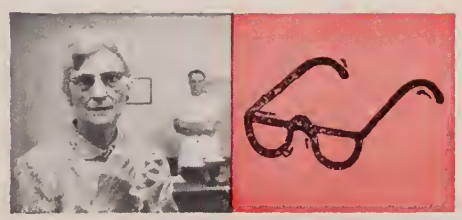
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(Continued from page 1372)

Dr. Jere W. Annis, of Lakeland, President of the Florida Medical Association, was one of the principal speakers on the program of the First Annual Florida Conference for Veterinarians held May 17 at the University of Florida in Gainesville. The Conference was sponsored by the University and the Florida Veterinarian Medical Association. Dr. Annis discussed "Professional Association Public Relations Program."

The Sixth Congress of the Pan American Medical Women's Alliance was held at the McAllister Hotel in Miami on April 13-17. Over half the registrants were from various Latin American countries. Dr. Tegualda Ponce, President, of Valparaiso, Chile, presided and was succeeded in office by Dr. Sarah D. Rosekrans of Neillsville, Wis. The chairman of the local arrangements committee was Dr. Alma Trappolini, and all of the Miami women doctors acted as hostesses.

Dr. Samuel R. Warson of Sarasota discussed "Community Responsibility" at the final meeting of the season for the Mental Health Association of Sarasota County held the middle of April at Sarasota.

Dr. Cornelia Morse Carithers of Jacksonville presented a paper in Miami on April 16 before the Sixth Congress of the Pan American Medical Women's Alliance at the scientific session devoted to Pediatrics. Her subject was "Children—Their Pets and Diseases."

The Greater Miami Pediatric Society held its ninth annual seminar the middle of April in Jackson Memorial Hospital at Miami. Guest speakers included Dr. Sydney S. Gellis, Professor of Pediatrics, Boston University School of Medicine, and Dr. Judson J. Van Wyk, Assistant Professor of Pediatrics, University of North Carolina School of Medicine.

Dr. Raymond J. Fitzpatrick of Gainesville was principal speaker at a mid-April meeting of the Rotary Club of that city.

Dr. Jean Jones Purdue of Miami served as moderator of the scientific session on Internal Medicine at the Sixth Congress of the Pan American Medical Women's Alliance, held in Miami April 13-17, and also presented a paper entitled "The Stroke Patient, Diagnosis and Handling."

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Each Pulvule 'Darvon Compound' provides:

'Darvon'	*32 mg.*
Acetophenetidin	*162 mg.*
'A.S.A.' (Acetylsalicylic Acid, Lilly)	*227 mg.*
Caffeine	*32.4 mg.*

*'A.S.A. Compound' (Acetylsalicylic Acid and Acetophenetidin Compound, Lilly)

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Drs. Hugh E. Parsons, R. Renfro Duke and Blackburn W. Lowry of Tampa attended the clinical meeting of the Wilmer Residents Association held early in April at the Wilmer Ophthalmological Institute of The Johns Hopkins Hospital and University in Baltimore.

Drs. M. Jay Flipse and Earlsworth C. Brunner of Miami have been presented 50 year medallions by the Dade County Tuberculosis Association for their service in combating tuberculosis.

Dr. Henry L. Harrell of Ocala, president of the Florida Academy of General Practice, Dr. Douglas W. Hood of St. Petersburg, and Dr. George W. Karelas of Newberry were among the group of Florida physicians attending the scientific assembly of the American Academy of General Practice held at Dallas. Dr. Karelas is chairman of the Committee on Rural Health of the American Academy.

Dr. Daniel M. Shapiro has been appointed Associate Professor of Surgery at the University of Miami School of Medicine. He was formerly associated with the Columbia-Presbyterian Medical Center at New York.

Dr. Samuel E. Kaplan of Venice was guest speaker at a recent meeting of the Venice Area Business and Professional Women's Club.

Dr. Mason Trupp of Tampa was one of the principal speakers at the meeting of the Southern Neurosurgical Society held at Jackson, Miss.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Brenner, Robert L. Jr., Fort Lauderdale
Cayia, Edward de R., Fort Lauderdale
Cornett, Eugene J., Tampa
Douglas, William M., Tampa
Ersay, Emil F., Pompano Beach
Ewing, Channing L., Belleview
Goyings, Ezra Jr., Winter Park
Hahn, Theodore W., Deerfield Beach
Hollander, Asher, Hollywood
Langley, Warren F., Pompano Beach
Sheahan, Robert C., Fort Lauderdale
Squires, John B., Fort Lauderdale
Updike, Edwin H. II, Ocala
Woulfe, James C., Fort Lauderdale



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Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

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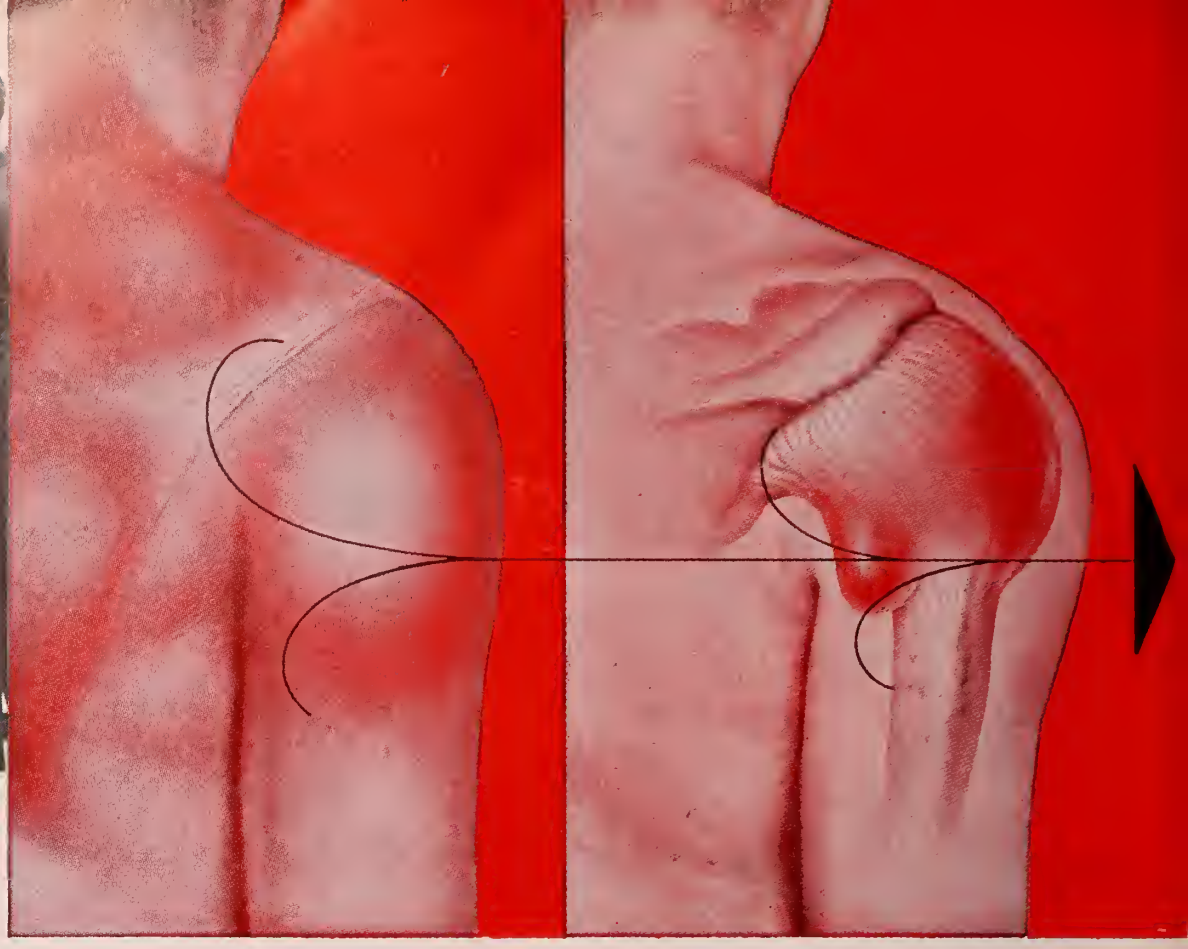
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Pectin (2 gr.)	142.8 mg.
Dihydroxyaluminum aminoacetate	0.25 Gm.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

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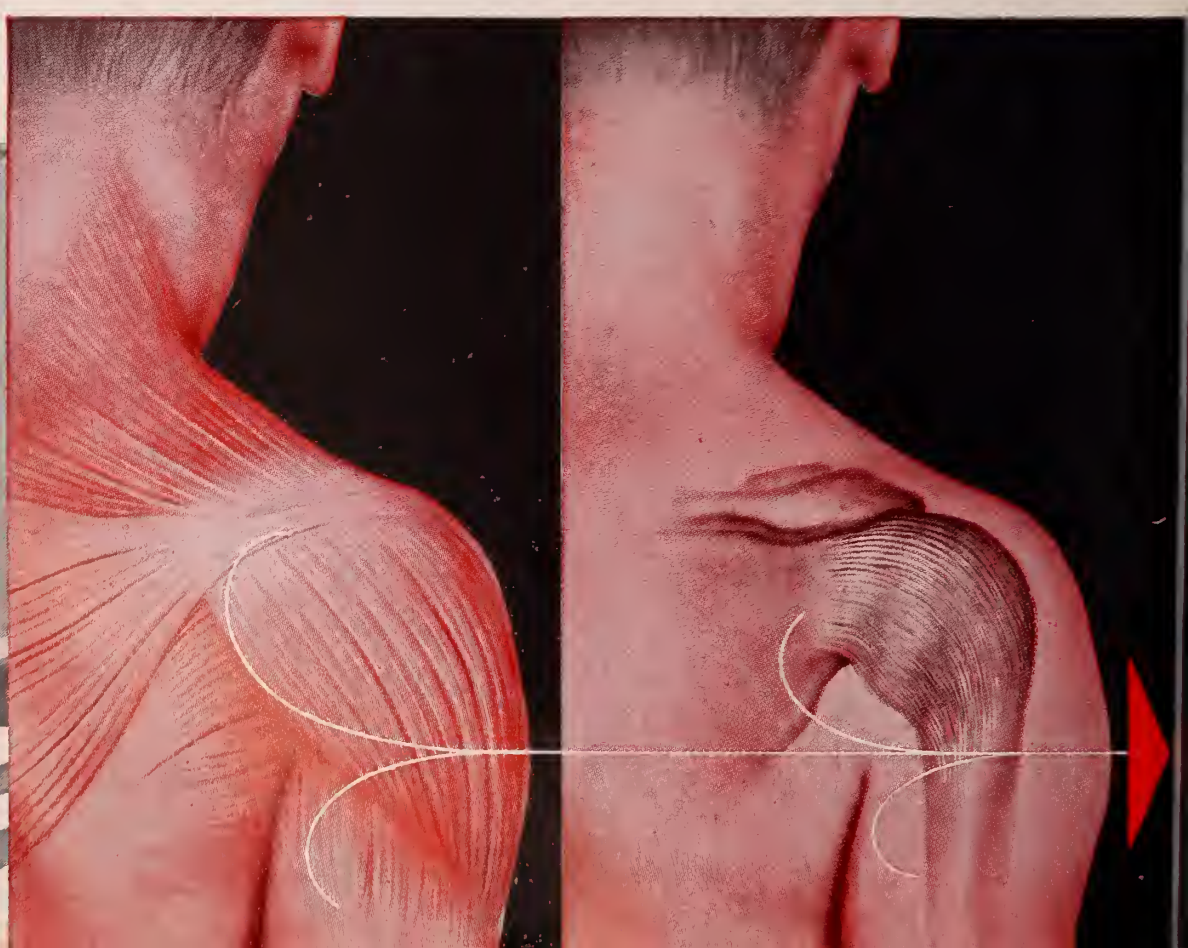
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muscles
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MEPROLONE-1—supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2.

1. Comroe's Arthritis: Hollander, J. L., p. 149 (Fifth Edition, Lea & Febiger, Philadelphia, Pa. 1953).
2. Merck Manual: Lyght, C. E., p. 1102 (Ninth Edition, Merck & Co., Inc., Rahway, N. J. 1956).

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COMPONENT SOCIETY NOTES

Collier

Dr. Paul Dudley White was principal speaker and guest of honor at a special meeting of the Collier County Medical Society held early in March at the Naples Community Hospital. Dr. White's subject was "Recent Interests in the Field of Cardiology." Other guests at the meeting included members of the Lee-Charlotte-Hendry County Medical Society.

Duval

Mr. Nelson Young, of the Professional Management Corp., Detroit, was principal speaker at the May meeting of the Duval County Medical Society. Mr. Young discussed a number of subjects including office overhead control, income tax problems, associates and partnerships, investments and estate planning.

Lee-Charlotte-Hendry

Dr. Edward Hamblen, Professor of Endocrinology at Duke University School of Medicine, Durham, was guest speaker at the March meeting of the Lee-Charlotte-Hendry County Medical Society.

Dr. Jere W. Annis, of Lakeland, President-Elect of the Florida Medical Association, was principal speaker for the Society's April meeting held at Fort Myers. His subject was pancreatitis.

The Society has paid 100 per cent of its state dues for 1958.

Leon-Gadsden-Liberty-Wakulla-Jefferson

Dr. Edward R. Woodward, of Gainesville, Chairman of the Department of Surgery at the College of Medicine, University of Florida, was guest speaker at the regular meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society held the middle of April in the W. T. Edwards Hospital at Tallahassee.

The Woman's Auxiliary to the Society met concurrently and installed Mrs. George H. Massey, of Quincy, as president.

Marion

Dr. Hugh B. Haston Jr., of Jacksonville, was principal speaker on the program of the April

(Continued on page 1383)

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meeting of the Marion County Medical Society held at Ocala. The title of his address was "General Considerations of Fractures in Children."

Pinellas

Dr. John E. Orebaugh, of St. Petersburg, was principal scientific speaker on the program of the May meeting of the Pinellas County Medical Society held in the Hurricane Restaurant, Pinellas International Airport. His subject was "Advances in Vascular Surgery."

Polk

Dr. Morris Fishbein, of Chicago, medical editor of Encyclopaedia Britannica, delivered an address at the April Meeting of the Polk County Medical Association held at Winter Haven. Dr. Fishbein was formerly editor of The Journal of the American Medical Association.

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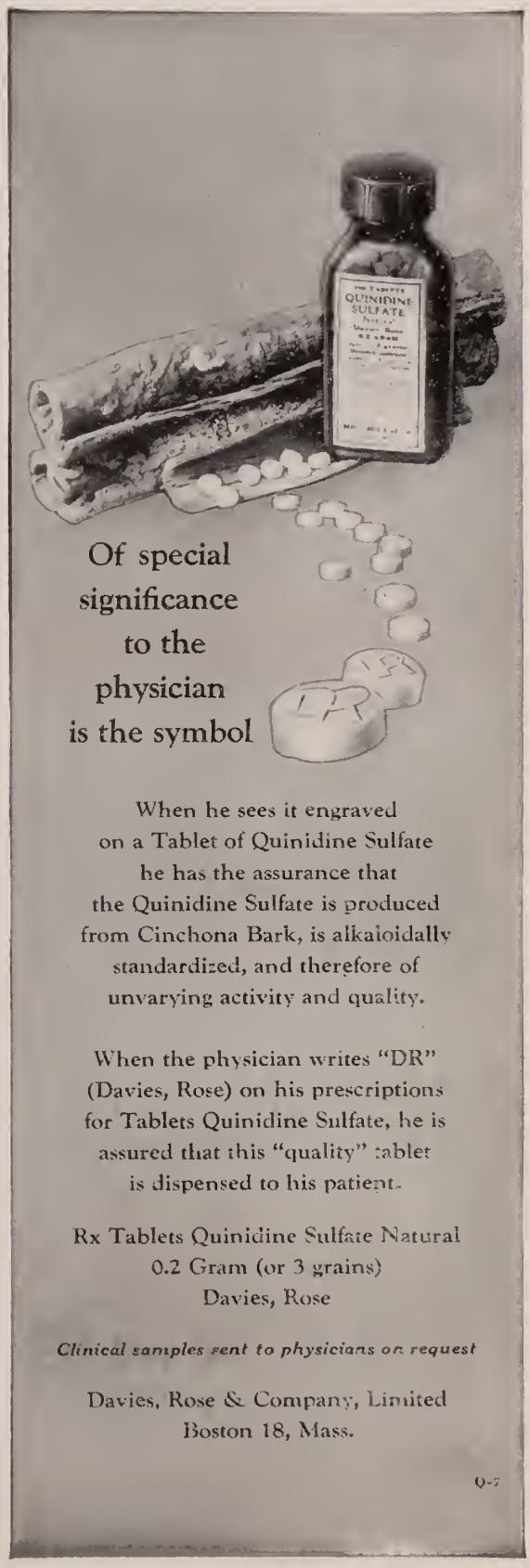
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CONDITION	PAT
STUDY 1[1]	
Skeletal muscle spasm secondary to acute trauma	
STUDY 2[2]	
Herniated disc	
Ligamentous strains	
Torticollis	
Whiplash injury	
Contusions, fractures, and muscle soreness due to accidents	
STUDY 3[5]	
Herniated disc	
Acute fibromyositis	
Torticollis	
STUDY 4[6]	
Pyramidal tract and acute myalgic disorders	
TOTALS	1



TE SKELETAL MUSCLE SPASM[1,2,5,6]

	RESPONSE		
ked"	*moderate*	*slight*	*none*
6	6	1	—
unced"			
5	13	—	1
4	4	—	—
3	—	—	—
2	1	—	—
3	2	—	—
llent"			
6	2	—	—
8	—	—	—
–	—	1	—
ficant"			
7	—	2	1
4	28	4	2
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References: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:374, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B.: Proc. Soc. Exper. Bio. & Med. 95:422, 1957. 8. Truitt, E. B., Jr., Patterson, R. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:189, 1957.

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BIRTHS AND DEATHS

Births

Dr. and Mrs. Alvaro Vargas, of Hialeah, announce the birth of a daughter, Marianne, on Feb. 18, 1958.

Dr. and Mrs. James G. Lyerly Jr., of Jacksonville, announce the birth of a son, William Mitchell, on March 2, 1958.

Dr. and Mrs. Robert H. Lester, of Arlington, announce the birth of a son, Robert Clark, on Feb. 21, 1958.

Dr. and Mrs. Richard T. Shaar, of Jacksonville, announce the birth of a son, William Mason, on Feb. 25, 1958.

Dr. and Mrs. Thomas S. Edwards, of Jacksonville, announce the birth of a daughter, Susan Crawford, on April 17, 1958.

Deaths-Members

Bell, John D. Pensacola	January 28, 1958
Bond, Benjamin, Winter Haven	February 28, 1958
Brown, Oliver C., Fort Lauderdale	March 10, 1958
Freedland, Marvin S., Coral Gables	March 8, 1958
Lisk, Percy F., Fort McCoy	January 22, 1958
Mendel, James H. Sr., Coral Gables	February 5, 1958
Moon, William B., Crystal River	March 20, 1958
Nickel, Frank W., Winter Park	December 22, 1957
Turnage, Johnson Lee, Crestview	March 19, 1958

Deaths — Other Doctors

Arnow, Matthew, Eustis	December 29, 1957
Miller, J. Preston, Miami	December 21, 1957
Ranney, Earl Albert, St. Petersburg	November 27, 1957
Sabshin, Zalmar Isaac, Miami Beach	December 21, 1957

Medical Licenses Granted

Dr. Homer L. Pearson Jr., secretary of the State Board of Medical Examiners, has reported that of the 325 applicants who took the examination of the Board, held November 25 and 26, 1957, in Miami, 275 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 275 successful applicants follow:

Adel, Frank Edward, Miami (U. Tenn. 1957)
Albee, Robert Dempster, Buffalo (U. Buffalo 1944)
Alfonso, Rafael, Baltimore (U. Havana 1948)
Alfred, Harry Charles, Fort Walton Beach (U. Tenn. 1946)
Allen, Arthur Charles, Miami (U. California 1936)
Alpert, Barnett Bertram, Hollywood (McGill U. 1932)
Anderson, Herbert Charles, Miami (Duke U. 1956)
Andrews, James Patten, Cleveland (Western Reserve U. 1950)
Angell, Joseph Samuel, Oak Park, Ill. (Rush 1937)
Antiles, Harold Robert, Brooklyn (Georgetown U. 1938)
Barnes, Claude James, Milton (Tulane 1954)
Barry, Patrick Joseph, Miami (Cornell 1957)
Batley, Louis Le Garde, Augusta, Ga. (Georgia Medical 1946)
Bauer, David Patton, Jacksonville (Emory 1952)
Bayer, Irving, Jamaica, N. Y. (U. Louisville 1941)
Benton, Fred Warren, Key Biscayne (Boston U. 1945)
Blechman, Wilbur Jordan, Richmond, Va. (Virginia Med. Col. 1957)
Bloom, John Desmond, Chicago (Stritch Sch. Med. 1953)
Bodaski, Albert Alexander, Tyler, Minn. (U. Minn. 1938)
Border, Clinton Larry Jr., Miami (U. Louisville 1952)
Boyd, George Hugh Jr., Clayton, Ga. (Georgia Med. Col. 1950)

(Continued on page 1394)



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1. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. *6*:580 (April) 1955.
2. Codling, J. W., and Lowden, R. J.: Northwest Med. *57*:331 (March) 1958.



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(Continued from page 1390)

Boyett, James Edward, Lafayette, Ala. (Harvard 1954)
Boynton, Bruce II, Grafton, N. D. (U. Minn. 1944)
Braun, Richard Allan, Fort Leonard Wood, Mo. (Western Reserve U. 1954)
Brennan, James Edward, Lakeland (Jefferson 1953)
Brodsky, Leonard, Miami (Jefferson 1953)
Brocks, Allan, Miami (Hahnemann 1957)
Brown, Robert William, New Orleans (Tulane 1950)
Brown, Stuart Irwin, Miami (U. Illinois 1957)
Browning, Louis DeLoach, Hopkinsville, Ky. (Harvard 1949)
Bunn, Joe Plummer, Jacksonville (Duke U. 1957)
Caffey, John William Jr., Chapel Hill, N. C. (Duke U. 1953)
Callaghan, Patrick Edward, Eglin AFB (Stritch Sch. Med. 1955)
Carter, Mary Jo, Coral Gables (Bowman Gray 1957)
Carter, William Franklin, Jacksonville (Emory 1957)
Cataldo, Marne, Oak Park, Ill. (U. Chicago 1945)
Celian, Charles Irving, Bay Harbor Island (U. Penn. 1955)
Cesarano, Francis Lewis, Miami (Syracuse U. 1956)
Christy, Raymond Arthur Jr., Gulf Breeze (U. Kansas 1954)
Clark, Francis Leslie Jr., Washington, D. C. (Georgetown U. 1954)
Claytor, Samuel Barton, Tampa (South Carolina Med. Col. 1956)
Cohen, Arthur Nathaniel, Miami (New York U. 1957)
Cohen, Noel Lee, Elberta, Ala. (U. Utrecht 1957)
Cole, John Harry, Orlando (Tufts 1951)
Cooper, Thomas Walker, Charlottesville, Va. (Bowman Gray 1955)
Craig, Louis Chastain, Charlottesville, Va. (U. Virginia 1954)
Cremer, Leonard Eugene, Jacksonville (U. Cinn. 1957)
Crisler, Morris McCaleb Jr., Edwards, Miss. (Tulane 1953)
Crow, Claude Robert, Orlando (Emory 1957)
Cullen, Julia Mary, Buffalo (U. Buffalo 1949)
Damron, John Russell, Fort Lauderdale (U. Louisville 1952)
Davenport, Oliver William, Key Biscayne (U. Arkansas 1952)
Davis, Herbert Harvey, Miami (U. Tenn. 1957)
DeHaan, Quentin Conrad, Miami (Columbia U. 1955)
de la Vega, Felix, Freeport, Ill. (U. Havana 1949)
Demming, James Henry, Philadelphia (Western Reserve U. 1954)
DeSimone, Vincenza Theresa, Tampa (Georgetown U. 1952)
Dever, Richard Curzon, Miami (Johns Hopkins 1952)
Donnelly, Elwin William, Fort Lee, Va. (Northwestern U. 1955)
Donovan, Daniel Lafayette, Chapel Hill, N. C. (Stritch Sch. Med. 1947)
Douglass, William Campbell, Sarasota (U. Miami 1957)
Dozier, Richard Moore, Tallahassee (U. Tenn. 1957)
Duckwall, Vernon Eugene, Elkins, W. Va. (Columbia 1941)
Dugan, Charles Clark, Jupiter (Jefferson 1946)
Durfey, John Quincy, Jacksonville (Columbia 1954)
Earp, William Lee, St. Petersburg (U. Penn. 1957)
Ellington, William Thomas, Miami (G. Washington U. 1956)
Facundus, Bruce Elton, Monroe, La. (Louisiana St. U. 1954)
Fein, Clayton Lewis, Detroit, Mich. (U. Ottawa 1954)
Ferguson, Edward Charles, Miami (Marquette 1951)
Fernandez, Mario, Miami (U. Havana 1940)
Fial, Edward Alexander, Buffalo (U. Buffalo 1946)
Fisher, Elbert Luther Jr., Tampa (Duke U. 1957)
Flanary, Jack Ronald, St. Petersburg (Virginia Med. Col. 1957)
Flood, Charles Crosbie, Gainesville (Georgetown U. 1938)
Fontaine, Catherine Silliman, Coral Gables (Women's Med. Penn. 1954)

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1. Russek, H. I.: Postgrad. Med. *19*:562 (June) 1956.

Dosage and Supplied: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. When indicated this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. ATARAX.) For convenience, write "CARTRAX 10" or "CARTRAX 20." In bottles of 100.

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Gabriel, Arthur N., Brooklyn (Emory 1957)
George, William Smith, Coral Gables (Washington U. 1929)
Getz, John Lewis Jr., Jacksonville (Georgetown U. 1948)
Gibson, James Wiley, Coral Gables (South Carolina Med. Col. 1951)
Gilmore, Elizabeth Pellett, Miami (U. Penn. 1950)
Gilson, Albert Jack, Miami (Cornell 1957)
Glass, MacEllis Kopel, Biloxi, Miss. (Harvard 1955)
Glenn, William Darby III, Eglin AFB (U. Penn. 1956)
Glotfelty, John William, Staten Island, N. Y. (U. Louisville 1953)
Gomez, Max Eulogio, Miami (U. Havana 1950)
Goodson, Michael Piers, Miami (Cambridge U. 1950)
Goyings, Ezra Jr., Biloxi, Miss. (Med. Col. Virginia 1948)
Grant, Edwin Harris, Miami (Alabama Med. 1957)
Green, Quentin Lafayette, New Orleans (Baylor U. 1948)
Gregory, Ledford Gerald, Beckley, W. Va. (Cornell 1949)
Grisell, Ted Lewis, Indianapolis (Indiana U. 1939)
Grumley, Ann, Miami (Tufts 1957)
Haddad, George Norman Jr., Miami (U. Oklahoma 1957)
Handte, Robert Earl, Miami (New York Med. 1953)
Harris, Henry William, Jacksonville (U. Tenn. 1957)
Haynes, William Ned, Coral Gables (Med. Col. Virginia 1953)
Heffner, Ralph Wesley, S. Miami (U. Penn. 1945)
Henderson, William Neavitt, Tulsa, Okla. (Duke U. 1946)
Hibbert, William Andrew Jr., Pensacola (Emory 1957)
Hill, William Farris Jr., Sebring (U. Tenn. 1956)
Hines, Kenneth Kay, Tampa (U. Buffalo 1957)
Hocker, John Thomas, Jacksonville (U. Kansas 1956)
Hopman, Bernard Cornelis, Miami (U. Amsterdam 1922)
Horwitz, Frederick, Miami (U. Michigan 1957)
Hurt, Walter Laverne, Lake Worth (Indiana U. 1953)
Hutson, Edward Douglas, Coconut Grove (Temple U. 1957)
Irish, Louise, Miami (Vanderbilt 1956)
Isley, Joseph Keener Jr., Durham, N. C. (Bowman Gray 1948)
Jaffee, Marvin Louis, Miami (Chicago Med. 1950)
Jahnke, Edward John Jr., Pittsburg (Jefferson 1948)
Johnson, Douglas Marion, Tampa (Duke U. 1955)
Johnson, Robert Peter, Key West (Tulane 1956)
Jones, George Richard Jr., Tampa (Temble U. 1957)
Kahana, Lawrence, Tampa (Washington U. 1953)
Kane, Wilton Rodgers, Crescent City (Jefferson 1956)
Kasner, David, Chicago (Tulane 1954)
Katz, Evan, Coral Gables (Chicago Med. 1956)
Keates, Edwin Utley, Elkins Park, Pa. (Jefferson 1957)
Keates, Richard Harry, Elkins Park, Pa. (Jefferson 1957)
Kessler, Nathan, Cross City (Phy. & Surg. Boston 1949)
Kunz, Lyle Bernard, Miami (Iowa St. U. 1953)
Kurzner, Howard, Miami (U. Arkansas 1957)
Lambert, Mark Orlando, West Palm Beach (Tulane 1957)
Landau, Gerald David, Miami (Syracuse U. 1957)
Largen, Thomas Leland, Eau Gallie (Med. Col. Virginia 1950)
Lester, Charles Franklin, Miami (Yale 1952)
Levine, Morris Joseph, Chicago (U. Chicago 1952)
Levy, Martin Edward, Miami (Hahnemann 1957)
Liechty, John Demerath, Orlando (Northwestern U. 1957)
Lovitz, Beryl, New Orleans (Tulane 1956)
Lubow, Henry, New York (New York Med. 1950)
Lusskin, Bret Leon, Miami (St. U. N. Y. C. 1957)
Lynch, John Anthony, Bethesda, Md. (St. Louis U. 1955)
McCarthy, John Ayers, Pittsburgh (Jefferson 1955)
McCoy, Donald Lewis, Tampa (U. Kansas 1954)
McMahon, Donald Jr., Metairie, La. (Tulane 1952)
Mahoney, John Richard, Dumont, N. J. (Tufts 1951)
Maile, Earle Joseph, Parks AFB, Calif. (U. Wisconsin 1949)
Maniatis, William Richard, Bridgeport, Conn. (Yale 1947)
Mann, Joel Barry, Miami (Hahnemann 1957)
Mann, Richard Manning, Pittsburgh (U. Pittsburgh 1951)
Margulies, Charles, Miami Beach (New York Med. 1941)

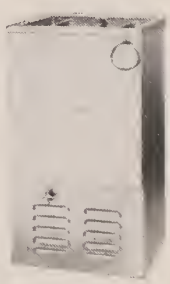
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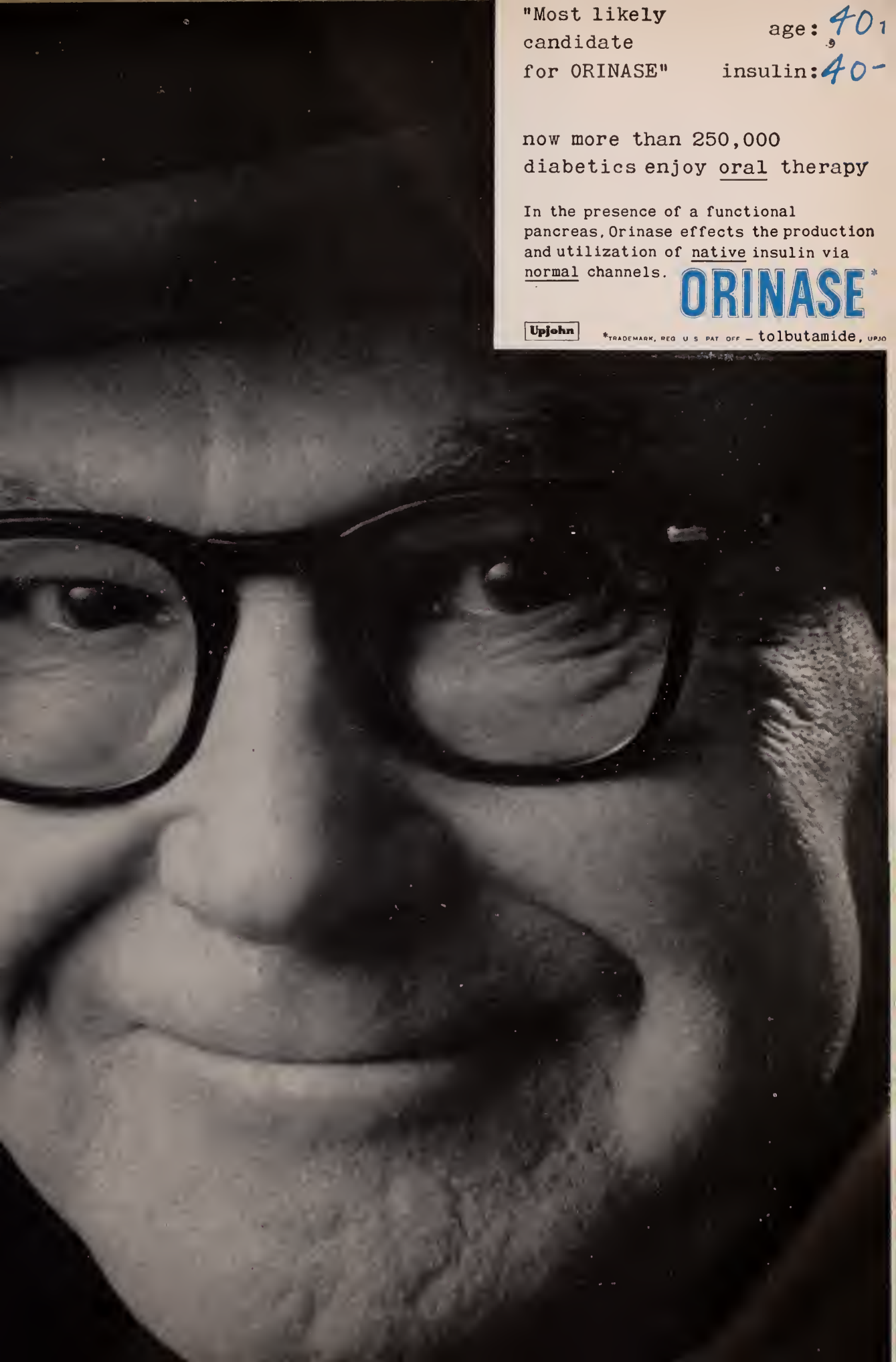
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Marks, Bernard Henry, Miami (Washington U. 1955)
Marsh, Myrle Frederick, Speedway, Ind. (Indiana U. 1954)
Martinez-Lopez, Jorge Ignacio, Metairie, La. (Louisiana St. U. 1950)
Maseda, Ramon Leoncio, Coral Gables (U. Havana 1945)
Matz, Martin Henry, Miami Beach (U. Penn. 1957)
Maultsby, Maxie Clarence Jr. (Col.), Orlando (Western Reserve U. 1957)
Mayer, Joan Weiss, Miami (Columbia 1954)
Mayer, Paul Wellman, Miami (Columbia 1954)
Maynard, Robert Ensign, Miami (U. Buffalo 1953)
Meltzer, Charles Curtis, Miami (Duke U. 1957)
Merrill, Carleton Russell Jr., Detroit (St. Louis U. 1954)
Messing, Samuel Louis, Miami (Syracuse U. 1957)
Metsch, Herbert, Surfside (U. Buffalo 1957)
Michals, Robert Anthony, Miami (Cornell 1957)
Millard, Max Solomon, Miami (U. Dublin 1944)
Miller, James Reynolds, Miami (Temple U. 1957)
Miller, Wallace Emil, Miami (Harvard 1944)
Mills, Henry Pipes Jr., Orlando (U. Miss. 1957)
Mitchell, John Potter Jr., Lantana (Tulane 1951)
Molina, Vincent Joseph Jr., Miami (Tulane 1957)
Montgomery, Brian Keys, Warrington (U. London 1950)
Moore, Rowe Price, Miami (Temple U. 1953)
Moreno, Gustavo Joseph III, Tampa (Georgetown U. 1952)
Mortimer, Raymond Edward, St. Petersburg (New York Med. 1951)
Moss, Jack William, Miami (New York Med. 1923)
Murphy, Ray Earlywine Jr., Dublin, Ga. (U. Louisville 1952)
Neder, George Abraham Jr., Jacksonville (Emory 1957)
Nelson, John Robert, Chattahoochee (U. Tenn. 1956)
Newell, Bruce Jr., St. Petersburg (Duke U. 1956)
Newell, Charles Harold, Omaha (U. Nebraska 1954)
Newman, Harry, Portland, Ore. (U. Oregon 1954)
Niswonger, Joseph Kingdon, Key West (G. Washington U. 1947)
Nitzberg, Saul Israel, Mattapan, Mass. (Emory 1951)
Nodine, Robert Carlton, Glen Oaks, N. Y. (Yale 1955)
Norris, James Ellsworth Chiles (Col.), Kilmarnock, Va. (Western Reserve U. 1957)
Offen, Joseph Allan, Coral Gables (U. Virginia 1949)
Ogle, Dan Clark, Washington, D. C. (U. Illinois 1929)
Olix, Melvin Leonard, Columbus, Ohio (U. Cinn. 1954)
O'Neill, James Flemister, Durham, N. C. (Duke U. 1954)
Parent, Charles-Henri, Fort Lauderdale (Laval U. 1946)
Parrish, Bruce Elliott, Cortez (U. Tenn. 1957)
Pavilack, Sidney, Tampa (Med. Col. Virginia 1957)
Piergeorge, Andrew Robert, Pittsburgh (U. Pittsburgh 1943)
Pike, Robert Edgar, Miami (U. Penn. 1955)
Polasky, Saul Hyman, Miami (U. Cinn. 1954)
Polizo, Dimitri Charles, Elizabeth, La. (U. Virginia 1955)
Potyk, David, Miami (Northwestern U. 1957)
Prout, George Russell Jr., Miami (Albany Med. 1947)
Quimby, Charles Sumner, Tampa (South Carolina Med. Col. 1956)
Ramsay, Reginald Carlyle, Raiford (Tulane 1953)
Rauch, Robert Joseph, Valley Stream, N. Y. (St. U. N.Y. C. 1953)
Reilly, Walter Malcolm, Tampa (Phy. & Surg. Boston 1948)
Rein, Harry, Fort Benning, Ga. (St. U. N.Y.C. 1957)
Rhea, James Wendell, Columbus, Ga. (New York Med. 1943)
Rice, Ruth Alta, Miami (U. Colorado 1956)
Rich, Joseph, Naples (Long Island Col. Med. 1934)
Rizika, Harold Paul, Miami (Syracuse U. 1953)
Robarge, Ignace James, N. Miami Beach (U. Michigan 1949)
Robinson, James Elbert, Chicago (Northwestern U. 1953)
Robinson, Robert Stith, Jacksonville (U. Tenn. 1957)
Roll, Edmond Charles, Orlando (Indiana U. 1942)
Ross, Carl, Jacksonville (Chicago Med Sch. 1943)
Ruche, Harry Charles, West Palm Beach (U. Md. 1923)
Rush, John Alfred Jr., Jacksonville (Emory 1957)





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Rush, Joseph Carl, St. Petersburg (Creighton U. 1952)
Saavedra, Diego, Miami (U. Havana 1947)
Sachs, Joseph, Brooklyn (N. Y. U. 1925)
Sakolsky, Robert Ivan, Miami (U. Geneva 1954)
Salko, Edward William, Cokeburg, Pa. (U. Pittsburgh 1943)
Salzman, Stanley H., Miami (Chicago Med. Sch. 1957)
Sanders, Norman, Miami (Syracuse U. 1957)
Sassano, Joseph Richard Jr., Rochester, Minn. (Georgetown U. 1954)
Schiff, Eva Gyori, Miami (U. Zurich 1951)
Schlesinger, Danial J., Munster, Ind. (Indiana U. 1944)
Schmidt, Carl Frederick, Milwaukee (U. Wisconsin 1956)
Schultz, Robert Jordan, Hempstead, L.I., N.Y. (Chicago Med. Sch. 1957)
Schwartz, William Lyle, Miami (U. Utah 1957)
Selph, James Anderson Jr., Richmond, Va. (Virginia Med. Col 1957)
Sena, Dominic Richard, Coral Gables (U. Perugia 1937)
Shaw, Eugene Russell, Williamsburg, Va. (U. Geneva 1952)
Shellow, Ronald Alan, Miami (U. Illinois 1957)
Sherman, Maurice Elish, New York (U. Buffalo 1957)
Shirley, Sheridan William, New Orleans (New York Med. 1953)
Siegel, Alan Arthur, Woodmere, L. I. N. Y. (Chicago Med. Sch. 1957)
Simon, Harold, Trenton, N. J. (Duke U. 1955)
Skigen, Jack, Miami (U. Pittsburgh 1957)
Smith, Dwight Raymond, New York (U. Chicago 1947)
Smith, Robert John, Jacksonville (U. Tenn. 1954)
Smith, Vernon Milan, Baltimore (Temple U. 1949)
Sokoloff, Martin Francis, Newport, R. I. (U. Louisville 1955)
Soshea, John William, St. Petersburg (Northwestern U. 1950)
Sperling, Adelle Bernice, Pensacola (Alabama Med. 1956)
Sporn, Irvin Norman, Richmond, Va. (Virginia Med. Col. 1957)
Starzl, Thomas Earl, Miami (Northwestern U. 1952)
Steck, Charles George, Gulf Breeze (Jefferson 1955)
Stiefel, John Raabe, Jacksonville (Emory 1957)
Strachan, James Boyd Jr., Birmingham, Ala. (Washington U. 1952)
Strauss, Albert, Baltimore (U. Virginia 1951)
Swartzendruber, Frederick James, Dearborn, Mich. (U. Illinois 1947)
Talmage, Edward Arthur, Miami (New York Med. 1952)
Tawfik, Harry David, Montgomery, Ala. (American U., Beirut 1945)
Taylor, Lawrence Carol, Rochester, Minn. (U. Nebraska 1955)
Terry, Robert Henry, Evansville, Ind. (U. Tenn. 1957)
Thomas, Henry Duke, Birmingham, Ala. (Alabama Med. 1952)
Thompson, Chester McConnell, Orlando (Temple U. 1953)
Tirone, Antonio Pietro, Richmond, Va. (U. Padua 1946)
Tompkins, William Alexander, Elmhurst, Ill. (U. Illinois 1947)
Traitz, James Joseph, Coral Gables (Temple U. 1945)
Trollinger, Robert James, Madeira Beach (Hahnemann 1957)
Trop, Jules, Miami Beach (Chicago Med Sch. 1957)
Vaughn, Betty Jean, Miami (Alabama Med. 1956)
Wagar, Anne Wilkinson, Winter Park (U. Georgia 1947)
Wahle, John Phillip Jr., Jacksonville (Emory 1957)
Walzer, Robert Steven, Miami (Columbia 1957)
Ward, Joseph Paul, Little Rock, Ark. (U. Arkansas 1953)
Wasserman, Fred, Miami (U. Virginia 1952)
Weise, Edmund Roland, Jacksonville (U. Virginia 1957)
Weiss, Edward Bernard, Great Lakes, Ill. (Duke U. 1957)
White, William Penn, Atlanta, Ga. (Emory 1957)
Whitman, Leo, Fort Lauderdale (Eclectic Med. Cinn. 1939)
Williams, William Tilden, Dunedin (Virginia Med. Col. 1947)
Wilson, Charles Arthur, W. Chester, Pa. (Virginia Med. Col. 1957)

(Continued on page 1406)

...to postpone the "G" point*...

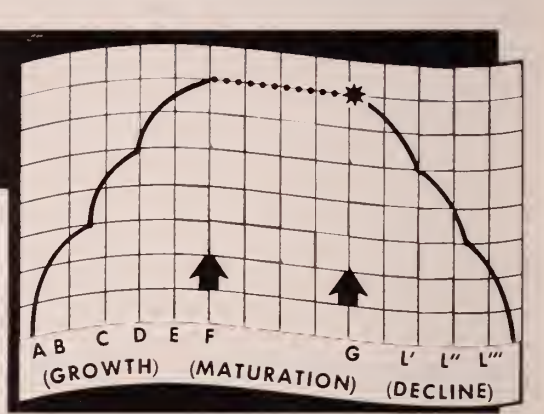
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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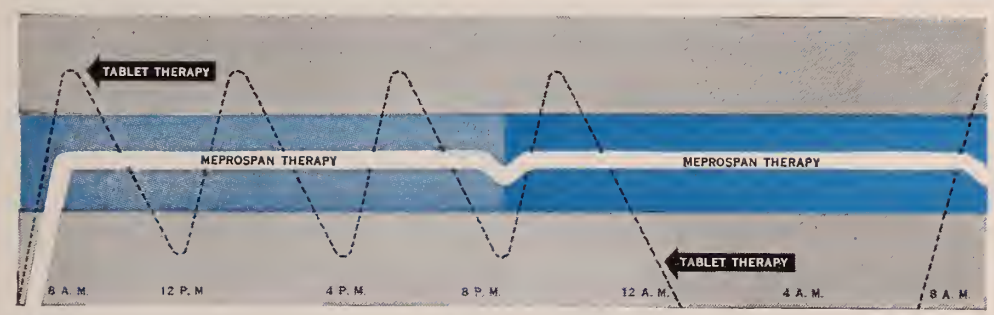
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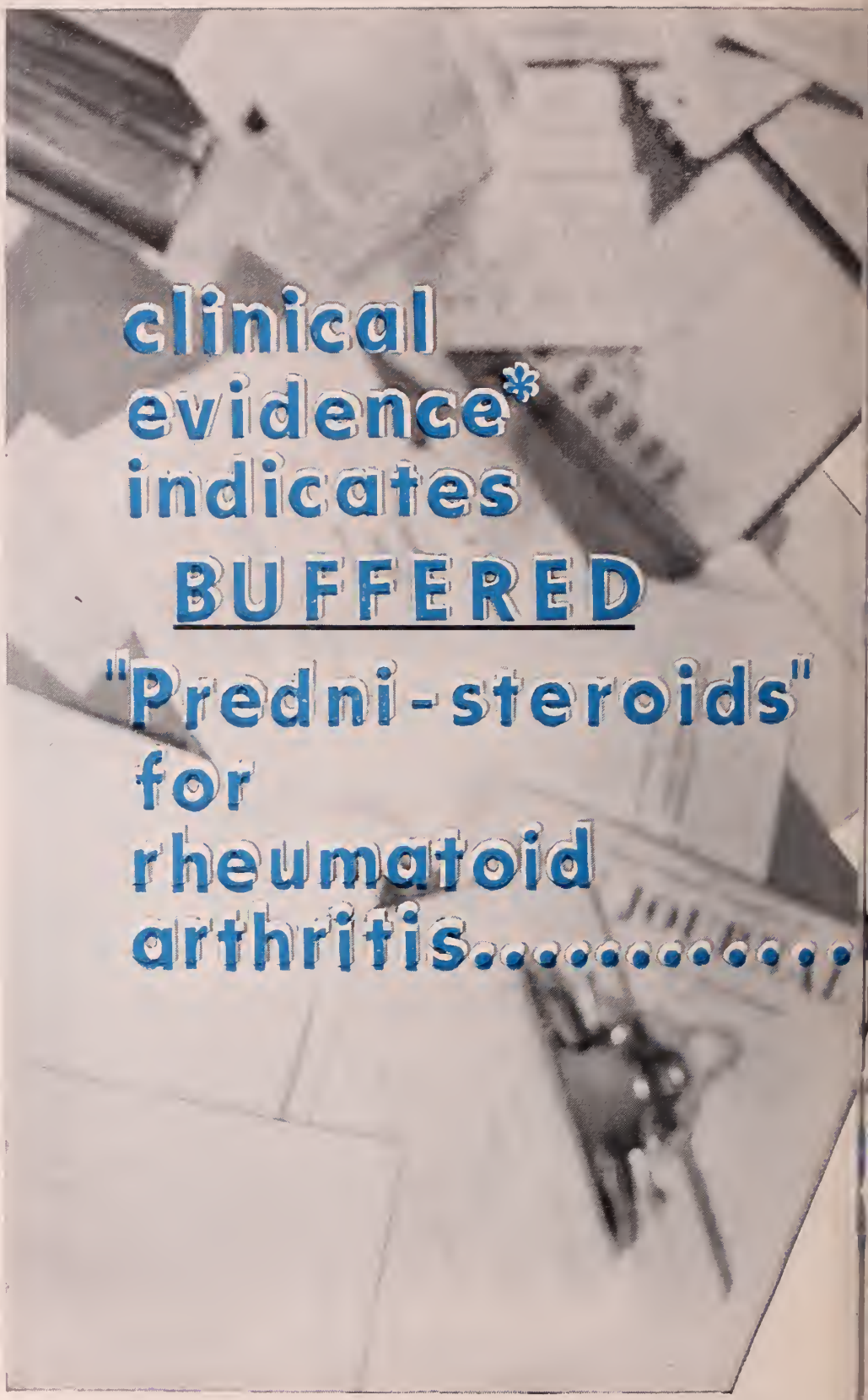
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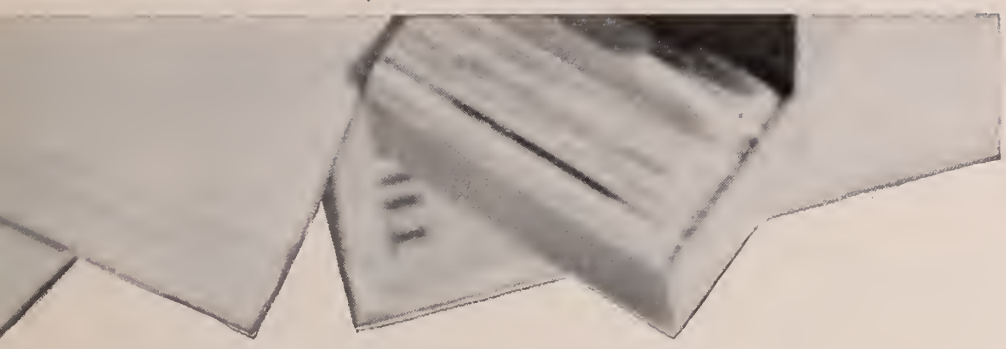
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iew of the beneficial re- observed when antacids d diets were used concom- ith prednisone and predni- e feel that these measures e employed prophylacti- offset any gastrointestinal ts."—Dordick, J. R. *et al.*: te J. Med. 57:2049 (June 7.

*"It is our growing conviction that all patients receiving oral steroids should take each dose after food or with adequate buffering with aluminum or magnesium hydroxide preparations."—Sigler, J. W. and Ensign, D. C.: J. Kentucky State M. A. 54:771 (Sept.) 1956.

*"The apparent high incidence of this serious [gastric] side effect in patients receiving prednisone or prednisolone suggests the advisability of routine co-administration of an aluminum hydroxide gel."—Bollet, A. J. and Bunim, J. J.: J. A. M. A. 158:459 (June 11) 1955.

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(Continued from page 1400)

Wolman, Irving Jacob, Philadelphia (Johns Hopkins 1929)
Wulfekuhler, Warren Vinson, Orlando (Tulane 1956)
Wyman, Edward Holbrook, Fort Lauderdale (South Carolina Med. Col. 1931)
Yerkovich, Anthony Cyril, Buffalo (U. Chicago 1939)
Yoder, John Robert, Ann Arbor, Mich. (U. Rochester 1954)
Young, Clifton Aurelius Jr., Dunedin (U. Tenn. 1956)
Young, James Norman, La Grange, Ill. (Northwestern U. 1950)
Zimskind, Paul Donald, Trenton, N. J. (Jefferson 1957)

OBITUARIES

Walter Bailey Johnston

Dr. Walter Bailey Johnston of Winter Park died suddenly at the Winter Park Memorial Hospital on Nov. 19, 1957. He was 55 years of age.

Born at Mineral Point, Wis., in 1902, Dr. Johnston had his premedical training in Florida at Rollins College and at the University of Wisconsin. He taught at Rollins College before entering medical school. He attended Western Reserve University School of Medicine and received his medical degree from that institution in 1931.

Dr. Johnston engaged in the practice of medicine in Cleveland, Ohio, until 1941 when he entered military service. He spent five years in the service of his country, holding the rank of lieutenant colonel in the medical corps of the United States Army. He experienced his first attack of coronary thrombosis after a period of continuous duty for 28 hours treating the wounded during the establishment of the Anzio beachhead and was never well thereafter.

Upon discharge from the service, Dr. Johnston accepted the post of senior physician for the Proctor and Gamble Company in Cincinnati, serving there until he came to Florida in 1947 and located in Winter Park. Until the time of his death he engaged in the general practice of medicine there with emphasis on obstetrics and gynecology. In 1955 he was named man of the year by the Winter Park Rotary Club for outstanding civic work with the Winter Park Health Clinic. Locally he was on the staff of Winter Park Memorial Hospital, Orange Memorial Hospital and the Florida Sanitarium and was the college physician at Rollins College. He was a member of the Congregational Church and active in the choir.

Dr. Johnston was a member of the Orange County Medical Society and for 10 years had held membership in the Florida Medical Association. He was also a member of the American

(Continued on page 1410)

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for dependable prophylaxis
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for immediate and sustained relief
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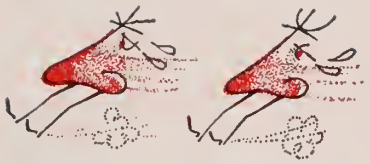
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Average prophylactic dose:
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Therapeutic dose:
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running noses . . .



caused by pollen allergies

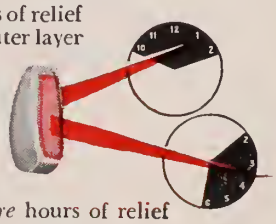
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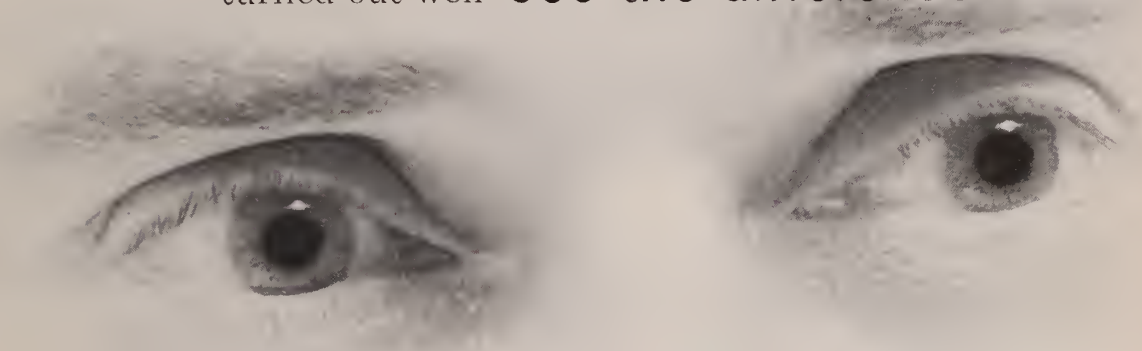
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*Howell, C. M., Jr.: Am. Pract. & Digest Treat. 8:1928, 1957.

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1. Grossmann, E. E., and Lehman, R. H.: Am. J. Ophth. 42:121, 1956.

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(Continued from page 1406)

Medical Association and the American Academy of General Practice.

Surviving are the widow, Mrs. Edna Wallace Johnston, and a son, Richard Johnston, both of Winter Park; two brothers, Willard A. Johnston of Chicago and Albert M. Johnston of South Dakota; and two sisters, Mrs. Katherine Fritz of Oak Park, Ill., and Mrs. Eunice Kretchman of Lansing, Ill.

Frank William Nickel

Dr. Frank William Nickel of Winter Park died in that city on Dec. 22, 1957. He was 75 years of age.

Born in Germany in 1883, Dr. Nickel received his premedical education in that country and at Hildreth College in Iowa. For his medical training he attended the University of Illinois College of Medicine in Chicago and was awarded the degree of Doctor of Medicine by that institution in 1910. He served an internship at the Cook County Hospital in Chicago and a residency in pathology at the Illinois State Hospital. He engaged in postgraduate study at Allgemeine Krankenhaus in Vienna and for a time was Assistant Professor of Pathology at the University of Illinois College of Medicine.

From 1912 to 1920 Dr. Nickel practiced general medicine in Eureka, Ill. He then moved to Peoria, Ill., where he continued to practice until he retired in 1947. At that time he came to Florida to reside at Palm Beach. After two years in retirement, he moved to Winter Park and reentered active practice continuing there until the time of his death.

Dr. Nickel was a member of the Orange County Medical Society, Florida Medical Association, American Medical Association and American Academy of General Practice.

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WOMAN'S AUXILIARY

Meet the President

In my recently appointed position as writer for the Woman's Auxiliary to the Florida Medical Association, I am pleased to introduce in this first article, our new President, Mrs. Lee Rogers Jr., of Rockledge, better known to a host of friends as Ann. We are indeed fortunate to have such a warm and friendly personality to represent our state this year.

Our Mississippi born President comes with a wide and varied background in medical social work as well as county and state Auxiliary jobs. She attended Mississippi State College for two years, receiving her B.A. degree from Mary Baldwin College, Staunton, Va., with a major in sociology and a minor in psychology. She received her master's degree from Tulane University, New Orleans, in medical social work. While in New Orleans she met her husband Lee, an intern at Touro Infirmary. He is now associated with the Kenaston Clinic in Cocoa as a surgeon. The third member of the family is a delightful thirteen year old daughter, Cally,—in her more dignified moments known as Ann Calvin.

While Ann's husband was receiving training in surgery at Lahey Clinic in Boston, she did medical social work at Boston Dispensary. Following this, she was Director of the Cooperative Nursery School at Shanks Village, N.Y., while husband Lee continued surgical residency at New York Post Graduate Hospital. To hear her describe this work reflects her love for children and the thrill she received from doing medical social work.

She has held many, many jobs in the Auxiliary, both on a county as well as state level. In Brevard county she has been Secretary-Treasurer, Vice-President, chairman of various committees, including Legislation this year. In state work, she has been Corresponding Secretary, Revisions and Resolutions Chairman, Southern Medical Auxiliary Councilor and Second Vice-President and Chairman of District B.

Aside from her Auxiliary work, there are many activities in the community in which she plays a major part. One registers no surprise at her comment that she has no time for hobbies. To see her tackle her many jobs, one realizes that her work is her hobby and she gets a real thrill from it all.

One of her most outstanding contributions is teacher of the Young Adult Sunday School Class of the Rockledge Presbyterian Church which she also serves as member of the Board of Deacons and as Secretary of the Building Committee. Other activities include Director, American Red Cross, various jobs in P.T.A., and many hours contributed to one of her special interest projects, the local hospital Auxiliary, where she dons her "Pink Lady" costume and donates hours of service.

The time worn statement that "if you want a job well done, pick the busiest person" truly fits here. I feel that we are indeed fortunate to have this outstanding personality as our President this year. It is my wish that each Auxiliary member in the state may have the opportunity of meeting her during her term in office.

Mrs. Albert F. Stratton Jr.

Auxiliary Officers

The names of the officers of the Woman's Auxiliary to the Florida Medical Association elected at the meeting held in May will be published as part of the next article by Mrs. Albert F. Stratton Jr., writer for the Auxiliary.




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BOOKS RECEIVED

Fear: Contagion and Conquest. By James Clark Moloney, M.D. Pp. 140. Price, $3.75. New York, Philosophical Library, Inc., 1957.

In this volume, the author mobilizes evidence from his experience as a psychoanalyst and from studies of people of various cultures to reinforce his conviction that "emotionally stable, normally integrated, emotionally mature adults develop by being afforded properly measured mothering" through the first three to five years of life. The facts assembled provide discerning and important insights into the behavior of the Chinese, the Japanese and the populations of such South Pacific islands as Bali and Okinawa, as well as Americans and Europeans.

The Neuroses and Their Treatment. Edited by Edward Podolsky, M.D., F.A.P.A., F.A.P.M. Pp. 555. Price, $10.00. New York, Philosophical Library, 1958.

Whatever one's definition of the neurosis, it remains the most common, the most widespread, and the most destructive of contemporary mental illnesses, making diagnosis, management and treatment of first importance to every physician in active practice. In this comprehensive survey of the field at present, Dr. Podolsky has selected some 40 representative papers containing the latest knowledge of specialists in the handling of all phases of the neurosis, from simple allergy to severe and crippling phobias, from psychotherapy in infancy to the handling of senility, from the routine psychotherapy to electroshock, and from the new psychopharmacologic aids to the extreme measures of lobotomy. Together, these authoritative clinical reports provide a valuable and illuminating cross section of the latest diagnoses and therapies from advance researchers in the field of mental illness. Among these reports is one entitled "Allergy and Psychoneuroses" by Dr. Frank C. Metzger of Tampa.

You Can Increase Your Heart-Power. By Peter J. Steincrohn, M.D., F.A.C.P. Pp. 381. Price, $4.95. Garden City, New York, Doubleday & Company, Inc., 1958.

Who does not want to make the most of his heart power? This book offers an excellent guide to that end —not alone to those who have already had heart trouble but also to those who wish to remain well and lead a full life. The author is an eminent heart specialist and internist and a nationally syndicated writer and author of many popular medical books for the layman. Dr. Steincrohn has written this book to show that "each one of us is the appointed caretaker of our heartbeats," and to explain the why's and wherefore's and do's and don'ts of our most important job in life. Each person, he estimates, has a lifetime of about three and a half billion heartbeats, and the object of his book is to help the reader use these heartbeats for a long, healthy, happy life.

Every aspect of heart disease, including imaginary heart trouble, is covered. Coronary problems, angina, high blood pressure, hardening of the arteries, proper diet, and overweight are thoroughly discussed in understandable language. The effect on the heart of exercise, alcohol, and smoking is explained and related to age and other factors. Caution and common sense are advised regarding the new low cholesterol diet. Dr. Steincrohn cautions against self-prescribed diets, and his urgent plea is to find a good doctor and follow his advice. He believes exercise is to be taken only in moderation after forty. Since it takes a 36 mile jaunt to walk off a pound of fat, he suggests skipping the pie a la mode as a better means of holding the weight line.

Part of the text is in the form of questions from patients and correspondents. These are fully answered with sound advice, gentle humor, and warm understanding. Reading this book may add years to one's life.

The Relation of Psychiatry to Pharmacology. By Abraham Wikler, M.D. Pp. 322. Price, $4.00. Published for the American Society for Pharmacology and Experimental Therapeutics by The Williams and Wilkins Company, Baltimore 2, Md., U. S. A., 1957.

The Editorial Board of Pharmacological Reviews assumes editorial responsibility for the material in this volume, which was originally intended for publication in Pharmacological Reviews, and the Board of Publication Trustees of the American Society for Pharmacology and Experimental Therapeutics subsidized the printing. Section 1, The Effects of Drugs on Human Behavior, deals with therapeutic procedures including the production of coma, "psychoexploration," tranquilization, and arousal and elevation of mood; diagnostic and prognostic testing procedures; and the production of "model" psychoses including rationale and syndromes. Section 2, Theories and Mechanisms of Drug Actions, presents an operational view of causal explanations of behavioral change; biochemical aspects, including theories relating changes in behavior to changes in cerebral metabolism and biochemical mechanisms of drug action; neurophysiological aspects, including theories relating changes in behavior to changes in neural organization, and neurophysiological mechanisms of drug action; and psychological aspects, including theories relating changes in behavior to changes in environmental adaption, and psychological mechanisms of drug actions.

Viewed from the standpoint of "experimental psychiatry," the material included in this review affords abundant evidence that investigation of the "mechanisms" of drug actions has served on the one hand, to detect and permit manipulation of a host of variables that may influence behavior, and on the other, to reveal the inadequacy of current theories which seek to relate such variables to behavior in a causal manner.





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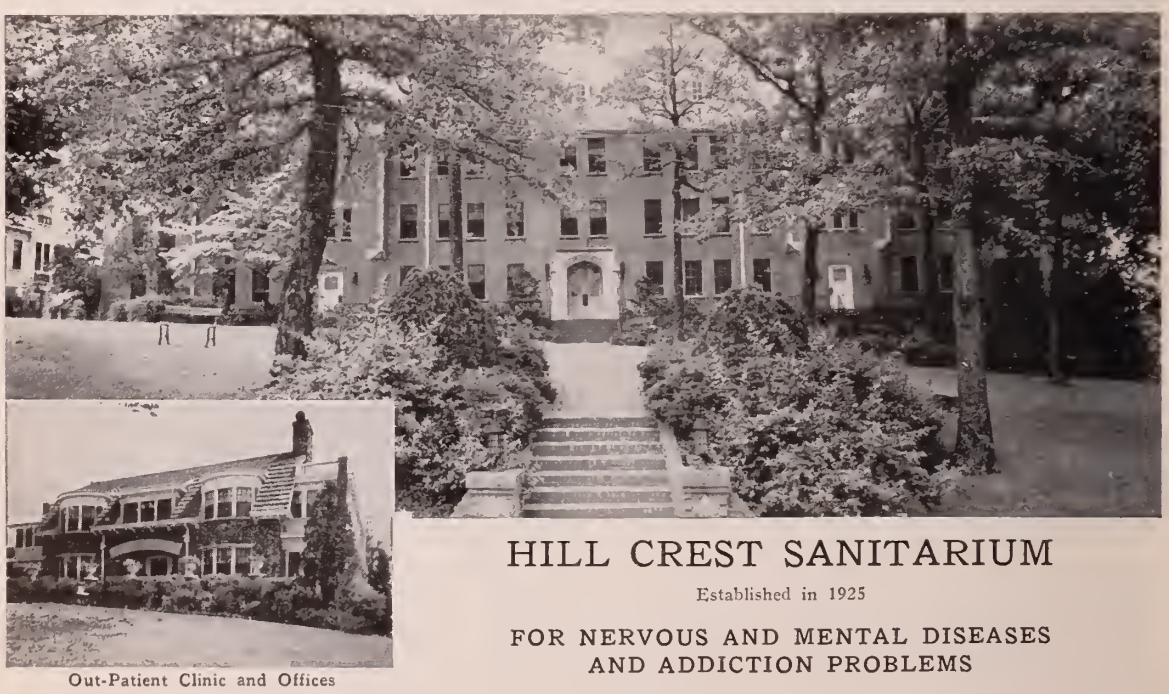
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Southeastern Surgical Congress	M. M. Copeland, Washington, D.C.	B. T. Beasley, Atlanta	Miami Beach, Mar. 9-12, '59
Gulf Coast Clinical Society	Lee Sharp, Pensacola	J. J. Baehr Jr., Pensacola	Pensacola, Oct. 23-24, '58
S.E. States Cancer Seminar			Tampa, Nov. 19-21, '58



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